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**An Exploration of First Time Motherhood:
Narratives of Transition.**

An Exploration of First Time Motherhood:
Narratives of Transition.

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A thesis submitted for the Degree of Doctor of
Philosophy.

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1929-2000

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Declaration.

I declare that this dissertation is the result of my own work. The following publications, based on my doctoral research have either been published or have been accepted for publication:

Miller, T.A. (1996) 'Exploring the process of becoming a mother: narratives and narrative construction around childbearing', *Medical Sociology News*. Vol.21 (3).

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Declaration.

The names of all research participants, their children, individuals mentioned by them and locations, have been changed for reasons of confidentiality.

Summary

The ways in which women experience and narrate their journeys into first time motherhood is explored through a focus on narrative construction and reconstruction. The unique positioning of childbearing - at the interface between the biological and the social - both shapes expectations and renders experiences which do not conform to idealised notions of motherhood, difficult to voice.

The 17 participants in this study were all white, working women, who were expecting their first child. In depth interviews were carried out on three separate occasions, both antenatally and postnatally, over approximately a year. The longitudinal dimensions of the study enabled narrative trajectories to be collected and strategic construction and presentation of narratives to be explored. The movement in and out of the worlds of work and home was found to provide different reference points from which to make sense of, and narrate, a shifting sense of self. Narrative has not previously been used to explore women's experiences of transition to first time motherhood.

Gathering women's narratives over time enabled different subjectivities to be explored and narrative layers to be discerned. The shifts made visible by this approach revealed the ways in which transition to motherhood is socially constructed and experienced within the context of differing professional and personal time frames. Within these competing time frames epistemological and ontological shifts take place. Eventually, epistemological and ontological security led women to challenge assumptions around mothering with which they may have previously collaborated. Feeling able to cope led to the voicing, retrospectively, of past difficult experiences. Narratives were reconstructed and professional constructions of 'normal' transition to motherhood, questioned.

The research suggests that needs can remain unvoiced in a context where diverse mothering experiences are *uniformly* measured. The implications of the research for policy and practise, which is based on normative preoccupations, is considered.

Chapter One

Becoming a mother: medicalisation and ideologies of motherhood.

Introduction.

Some events that are highly significant for private lives and personal biographies are also very publicly defined affairs. The event of childbirth and process of women becoming mothers have major significance for individual biographies and are also publicly defined. Yet unlike some other life events, transition to motherhood is surrounded by pervasive ideologies - both biologically determined and socially constructed - which can be clearly discerned before and long after a child is born. It sits at the interface between the biological and the social. The period of transition to motherhood, from confirmation of pregnancy to identification with the role of mother, is then both a public event and a very personal experience. During this process women becoming mothers are confronted with an array of public and lay knowledges through which their expectations and experiences of motherhood will be mediated. Yet, the positioning of reproduction and childbearing at the interface between the biological and the social can be seen to 'regulate' women's experiences of becoming a mother and motherhood. The medicalisation of childbearing in conjunction with the pervasive ideologies which shape expectations of 'motherhood' both powerfully reinforce notions of appropriate ways of preparing for becoming a mother and how a 'good' mother 'naturally' acts. Yet for some women, the experience of becoming a mother does not resonate with expectations, as the gap between ideology and lived experience can appear bewilderingly large and at the same time difficult to voice in a society where motherhood and family life are closely related to being a 'moral' person. The focus of my research then is to explore the ways

in which women negotiate and narrate their transition to motherhood, how they *make sense* of becoming a mother for the first time.

The Medicalisation of Childbearing.

The placing of childbirth within a medical context and setting is, by now, well documented (Donnison, 1977; Oakley, 1979; Graham and Oakley, 1986; Garcia, Kilpatrick and Richards, 1990; Rich, 1977; Tew, 1990). The move away from domiciliary midwife care to hospital based, male dominated care that has occurred over the last 50 years has served to reinforce the illness view of pregnancy and childbearing. By the 1970s virtually all babies were born in hospital, the normality of pregnancy and childbirth only being acknowledged once delivery had taken place (Garcia, Kilpatrick and Richards, 1990). Pregnancy and childbirth have become medicalised, redefined as pathological rather than natural states, requiring medical regulation and 'supervision' and professional management (Tew 1990, Nettleton, 1995, Foster, 1995). As Ussher has commented, "pregnancy, childbirth and the postnatal period have been pathologised...positioning women's experiences as an illness in need of intervention" (1992:47). Along with the shift in place of birth, the development of routinised antenatal care has also occurred. Regular visits to general practitioners (GP's) and hospital clinics during the antenatal period have become generally accepted by women as an integral and necessary part of the childbearing process. As Oakley has observed, in our society there is a 'cultural dependence on professional health care' (1979:15).

The shift in place of birth from home to hospital reflects both the changes and continuities in women's lives and the material circumstances in which they live, which have occurred over the last century. Whilst the placing of childbirth into the hospital setting has been explained in terms of patriarchy and male dominance and control over women's bodies (Oakley, 1979; Martin,

1990; Treichler, 1990; Foster, 1995), it must at the same time be acknowledged that women themselves campaigned for the right to anaesthesia and hospital births during the earlier part of this century (Lewis: 1990:15). Demand came from both middle class and working class women who, for very different reasons, wanted access to hospital beds and facilities for childbirth. In conjunction with this, a concern with high infant mortality and maternal mortality rates during this period led policy makers and doctors to conclude that 'the answer was to hospitalise childbirth' (Lewis, 1990:21). It is clear now, that whilst some women had actively sought to place childbearing within a hospital context and that this had coincided with the wishes of the policy makers and doctors at the time, the seeds of medicalising childbearing had been sown. The process of gradually relocating childbirth in a hospital - and therefore illness - setting and the consequent pathologising of childbirth had begun.

By 1946 54% of all births occurred in hospital, reflecting a national drive to increase the number of maternity beds, and by 1998 the figure had risen to 98% (Social Trends, 1998). The links between lowering both perinatal and maternal mortality rates and issues of safety have become inextricably bound in defending the shift to hospital based deliveries. As Treichler has noted "state interests in maternity care often use the language of safety and paternity" (1990:128). Yet the extent to which 'safety' measured in terms of lowered perinatal mortality rates can be attributed to better maternity care has been a matter of some debate and in more recent years has been challenged (Tew, 1990; Foster, 1995). Campbell and Macfarlane have concluded that 'the results of a number of studies (have) been published which tend to suggest that the relationship between hospital delivery rate and the decline in perinatal mortality was spurious' (1990:221). Oakley (1993) has also challenged the medical practice of attributing 'greater safety in childbirth wholly to better

medical care' whilst ignoring other factors such as women having fewer children and the population as a whole being healthier. More recently in a Government response to the Winterton report it was acknowledged that 'the policy of encouraging all women to give birth in hospitals cannot be justified on grounds of safety' (1992, para33:7).

Yet perceptions of safety remain a persuasive factor in women's 'choice' of place of birth. For women expecting a child, interaction with the medical model, that is services and health professionals during the antenatal period can be 'seductive', compliance being equated in some way with safety. As Treichler (1990) has noted "state interests in maternity care often use the language of safety and paternalism" (1990:128). Indeed women who do not use antenatal services in an 'appropriate' way may be regarded as 'feckless' (Miller, 1995:17). By interacting with the medical model, attending clinic appointments, submitting to routine blood and urine tests and other technological interventions, a woman is perceived as preparing in an appropriate way for motherhood. In return, responsibility for the pregnancy is in some way transposed, a 'safe birth' becoming part of an equation in which a woman's control and power may be eroded (Foster, 1995; Lupton, 1994). A dependence on 'medical experts' has evolved within Western societies (Illich, 1976; Turner, 1995) and one aspect of this medicalisation process is that childbirth has become reconceptualised in terms of 'clinical safety' (Nettleton, 1995).

The medicalisation of childbearing then has been a gradual process in which claims of safety have been used to justify the *relocation* and the *reprioritising* - from midwife to obstetrician - of who has responsibility and who cares for childbearing women (Robinson, 1990; Oakley, 1993; Annandale, 1998). Inherent within debates around medicalisation are issues of power and,

specifically in relation to reproduction and childbearing, patriarchy. Feminists have differed on the positions they have taken to explain the shifts which have occurred around childbearing and the place of childbearing itself in women's lives, and this "like the competing claims of patriarchy and capitalism as controlling structures, has been a theme of debate for feminists" (Oakley 1993:11). Shared by all feminisms then is the "understanding that patriarchy privileges men by taking the male body as the 'standard'...and, through a comparison, viewing the female body as deficient, associated with illness, with lack of control and intuitive rather than reasoned" (Annandale & Clark, 1997:19). It is on this basis, feminists would argue, that male control over reproduction and childbearing has been achieved.

So, whilst feminisms share a common understanding regarding patriarchy, feminists have been divided on the more basic question of whether reproduction itself is even desirable (Firestone, 1971). Addressing the wider context of medicine, Lupton has usefully encapsulated the tensions which have existed in feminist writing over "the uniqueness of women's embodied experience and the desire to deny that any such uniqueness exists" (1994: 131). Whilst radical feminists have argued that "patriarchy seeks to control reproduction" (Annandale, 1998:72) and some talk of the oppressive nature of entering motherhood, others have celebrated the unique power of women's bodies to produce children - reproduction being seen not as oppressive, but as offering women the possibility of experiencing a 'pure and original femininity' (Annandale & Clark, 1997:26) beyond patriarchal and social control (Chodorow, 1978; Gilligan, 1982; Daly, 1973). The dilemma for feminists according to Blum has been "how to retain the empowering or pleasurable aspects of motherhood without reinforcing the straitjacket of traditional gender arrangements" (1993:292). The 'profound ambivalence' experienced as a mother - and a feminist - is described by Gieve who writes

of "the unexpected passion and joy and physical attachment on one side, and on the other side the relentless obligation and the necessity to respond which has deprived me of my own direction and brought the fear that I myself would be extinguished" (1987:39).

Feminist debates have also focused on the representation of the female body and the ways in which this is linked to particular 'ways of knowing' (Martin, 1990; Lupton, 1994; Sbisà 1996). As Rich has argued "throughout history, the woman's body is the terrain on which patriarchy is erected" (1977). Sbisà has also written of the need to "deconstruct the allegedly neutral dominant discourse about the female body" (1996:364) and others have noted the analogy of the female body to a (dysfunctional) machine (Martin, 1990; Oakley, 1993). Accounts of the female body as a 'deficient' male body and the use of metaphors of failure around reproduction, childbearing and menstruation have not gone unchallenged (Martin, 1987, 1990). The importance of listening to women's own accounts of bodily experience and privileging these, is emphasised in some recent work (Denny, 1996; Miller, 1998; Martin, 1990). Although the dangers inherent in universalising women's experiences must also be noted. In her critique of science and women's bodies Martin challenges the privileged position of science and uses accounts of menstruation to explore how women's "selves and bodies are oppressed in specific ways by biological knowledge" (1990:72). Importantly, Martin acknowledges that science must be explored in relation to the historical conditions under which it was produced. So too, individual experiences can only be explored within the context of "particular localities...(and) historical moments, and particular contexts of class and ethnicity" (Edwards & Ribbens 1998:8).

The privileging of (male) scientific 'knowledge' over female experience has been a recurrent theme in accounts of medicalisation (Foster, 1995; Oakley, 1979; Martin, 1990; Lupton, 1994, Stanworth, 1987). Debates have centred on what counts as 'knowledge' and how different 'ways of knowing' are ordered (Stanley and Wise, 1983; Stanley and Wise, 1993; Stanley, 1990; Griffiths, 1995). Questions of epistemology focus on what can be defined as 'knowledge', when and how, and how particular knowledges are ordered. Debates around epistemology are often presented as a united challenge to male 'mainstream' knowledge, which is presumed to constitute a unified and coherent whole. But such an approach is in danger of polarising any useful interchange and ignores differences *within* and between groups. As Ruddick has commented "recent feminist literature abounds in disputes over epistemological possibility and political consequences of making claims about 'women'" (1992:176). Traditional epistemologies have however been absorbed with a search for measurable, objective 'truths', and have excluded personal experience and politics from their search. 'Traditional epistemology' according to Griffiths is that which "springs from Descartes, Locke, Hume and Kant...and their fascination with the possibility of certainty and objectivity" (1995:56). Challenges to this traditional approach have not just been mounted by feminists - poststructuralists and postmodernists have similarly been concerned with the need to consider the subjective, and the inherent problems of power in any knowledge claims (Lyotard, 1986; Fox, 1993).

Knowledge production and power, medicalisation and patriarchy are then recurrent and interwoven themes, discernible in any analysis of the shifts which have occurred around reproduction and childbearing in western cultures (Oakley, 1993; Lewis, 1990; MacIntyre, 1981; Donnison, 1977; Treichler, 1990; Foster, 1995). Encapsulating these themes, Oakley has

argued that "in the contemporary industrial world, medical science and allied disciplines, in claiming specialist jurisdiction over all aspects of reproduction, have become the predominant source of social constructs of the culture of childbirth" (1993:20). Indeed it could be argued that the hospital is now culturally accepted as the 'natural' setting for childbirth in a society where everyday aspects of life are increasingly medicalised and 'expert knowledge' increasingly sought (Illich, 1976; Turner, 1995; Foster, 1995; Fox, 1993). Technological advances have also served to reinforce claims of expertise, providing practitioners with the tools to monitor 'progress' during pregnancy and childbirth. Screening has become a routine part of medical antenatal care enabling the identification of women, whose unborn baby may be 'at risk' of a particular disorder, being offered further tests or termination of the pregnancy (Reid, 1990). Yet whilst screening has become an integral part of pregnancy - so much so that some women may feel deprived if not offered various screening tests and may even purchase them privately¹ the social and moral issues it raises are complex. As Reid has pointed out "one of the critical issues inherent in any discussion of screening concerns abortion" (1990:313). And whilst women may eagerly anticipate their first ultrasound scan - taking along partners and other family members and purchasing the resulting photograph - far from being routine, the ultrasound may reveal serious deformities and place the pregnancy in jeopardy (Reid, 1990).

Screening then represents a further aspect of the medicalisation of pregnancy and childbearing and again encompasses the themes of power, patriarchy and expert knowledge claims. And whilst many women willingly engage with routine screening antenatally, and derive comfort from results confirming the 'normality' of their unborn child, the continuing shifts in how pregnancy is

¹One participant purchased several tests privately through a London clinic when she was unable to access them through the National Health Service (NHS).

'expertly' managed are in danger of further distancing women from 'knowing' their own bodies (Lupton, 1994; Treichler, 1990, Boston Women's Health Book Collective, 1978). The implications of this are wide ranging and will be further discussed later in this Chapter. However what is of concern here is that whereas it may be assumed that those involved in the 'expert' management of pregnancy and childbearing and those who are pregnant share a common understanding of pregnancy, fundamental differences have been found to exist (Graham and Oakley, 1986; Layrea, 1989; Macintyre, 1981; Oakley, 1979; Raphael, 1975). In their study based on data collected in the early 1980's in York and London, Graham and Oakley found "that doctors and mothers have a qualitatively different way of looking at the nature, context and management of reproduction" (1986:99) and they concluded that they operate with different 'frames of reference'. These findings have been supported by other research (Laryea, 1989; Barclay et al, 1997). The context of reproduction and childbearing then is not only differently interpreted and experienced, but needs to be understood in terms of the pervasive ideologies which surround it.

Ideologies of Motherhood

Whilst the implications of the medicalisation of childbearing for women has been to shift "the focus of birth from the social and emotional to the physiological and medical" (Garcia, Kilpatrick and Richards, 1990:3), the ideologies which can be clearly discerned before and long after a child is born remain a powerful force in shaping expectations. The biological fact of giving birth within our culture simultaneously leads to a redefinition of an individuals identity as being inextricably linked to family and motherhood - that a woman's fate is tied to her biological role in reproduction (Romito, 1997; Oakley, 1979; Richardson, 1993). This transition occurs, as Letherby has noted, "against a background of personal and cultural assumptions that

all women are, or want to be mothers" (1994). And whilst these assumptions have increasingly been challenged and attempts made to separate motherhood from female identity the tendency to conflate these identities has continued (Ireland, 1993; Letherby, 1994, Phoenix and Woollett, 1991). As Phoenix and Woollett have observed, "regardless of whether women become mothers, motherhood is central to the ways in which they are defined by others and to their perceptions of themselves" (1991:13). Dominant ideologies of motherhood are rooted in assumptions of biological determinism and the inevitability of women's destiny to become mothers. Fundamental to such powerful ideologies is the notion that mothering is biologically determined and therefore universally experienced and constant. Yet historical, social and cultural variations have been clearly demonstrated which Glenn argues "confirms that mothering, like other relationships and institutions, is socially constructed, not biologically inscribed" (1994:3).

Ideologies then also shift over time and ideas about what a 'good' mother should do - stay at home and devote herself to childrearing and housework - shift according to public and political changes. This can be seen in the current policies of New Labour which appear to encourage women to combine mothering with paid employment (which may indeed be paid 'mothering' of other women's children) thus redefining the roles and expectations of what constitutes a 'good' mother (Urwin, 1985; Phoenix and Woollett, 1991; Miller, 1998; Segura, 1994). The dynamic nature of ideologies around mothering thus becomes clear and, as Glenn has commented, must be seen within the context in which they are produced, that is "through men's and women's actions within specific historical circumstances" (Glenn, 1994:3). Agency then becomes a crucial feature in any analysis of motherhood as a social construct. *Situating* experiences of being a mother also becomes key if an essentialist position is to be avoided.

As Collins has argued "for women of color (sic), the subjective experience of mothering/ motherhood is inextricably linked to the sociocultural concern of racial ethnic communities - one does not exist without the other" (1994:47). Dominant ideologies around motherhood then can be seen to represent the ideas and beliefs of more powerful groups and do not recognise or accommodate the diversity of women's lived experiences. And yet they are pervasive, and powerfully shape both society's expectations and women's own expectations of what mothering is all about, as Manion has commented "motherhood is women's greatest hope and greatest anxiety: it is pathogenic, pathological, but it is the ultimate romance. Nothing could be more confusing" (1988:186).

Since the 1960's feminists have challenged the ideologies which surround mothering, Attempts to theorise motherhood without recourse to 'natural or biological explanations' have been attempted (Glenn, 1994). Using psychoanalytic object relations theory, Chodorow (1978) has sought to demonstrate how being mothered by women transmits and reinforces a pattern of female mothering. This is not biologically determined but a product of the dynamics of the mother-daughter relationship which differs from the mother-son relationship. In order to change expectations around mothering, Chodorow argued that men must participate more equally in childrearing to redress the gender balance of nurturing/caring. Ruddick (1980) too has argued that mother's concerns for nurturing and protecting their children can be explained through 'maternal practice'. The higher philosophical thought which is required to nurture and the acts involved in doing mothering are not biologically determined but arise from constant practice. The positions taken by both Chodorow and Ruddick have been criticised for, amongst other things, universalising experiences of

motherhood and not challenging the 'status quo' (Phoenix and Woollett, 1991; Delphy, 1992; Glenn, 1994).

In contrast, pro family ideologies - which have been dominant in America and bound up with the political Right in Britain and more recently New Labour - are rooted in perceptions of motherhood as biologically determined. Conservative and pro family feminism has focused on the "life giving values associated with mothering" (Delphy, 1992:18). Such ideology has served to emphasis "mothering as women's primary and exclusive identity" and in so doing locate women firmly in the home, the private sphere (Glenn, 1994; Richardson, 1993). It is these elements of an ideology which is rooted in patriarchy that other feminists have argued turn mothering into an alienating and oppressive experience (Rich, 1977; Oakley, 1979). And yet such challenges have not radically changed the dominant ideologies which powerfully and pervasively surround motherhood. Even though household and living arrangements have changed dramatically over the last 25 years, ideologies around 'good' mothering persist and override current living arrangements (Phoenix and Woollett, 1991). As Romito notes "the problem is that despite twenty five years of the new feminism, motherhood still retains its sacred aura. Mothers still do not dare to admit how burdensome the constraints and difficulties of their condition can be" (1997:172). Reflecting on her own experiences of being a mother, Gieve notes that the "fear of the knot of motherhood has made us turn away from confronting it" (1987:39). And therein lies the paradox for women. The unique positioning of childbearing - at the interface between the biological and the social - both shapes expectations and renders experiences which do not conform to some idealised notion of motherhood difficult to voice. Adrienne Rich (1977) notably drew attention to the distinction between the *experience* of motherhood and the *institution* of motherhood, and it is the potential clash,

according to Oakley, "between the reality of motherhood...and social expectations of women as mothers" which has been a key factor in the development of feminism itself (1993:162).

During the 1970s and early 1980s feminists working from different disciplines and theoretical perspectives continued to argue for and against the uniqueness or otherwise of women's ability to become mothers (Daly, 1973; Chodorow, 1978; Gilligan 1982; Ross, 1995; Lupton, 1994). A shift to focus on 'reaffirming and celebrating motherhood' is discernible in feminist literature in the later 1980s and 1990s (Ross, 1995:398) (Ruddick, 1980; Ribbens, 1998; Gieve, 1989; Delphy, 1992; Lazarre, 1987). Yet the perspectives from which motherhood has been explored has remained relatively limited. Ross (1995) having experienced the (unimaginable) death of her only child, writes of the "dramatic shortage of writing recognising all sides of mothering" (1995:398). Darley (1989) too has written movingly of the loss of a child, of having briefly glimpsed motherhood, and the strength that she has derived from that to enable her to carry on. Phoenix and Woollett (1991) also note the tendency for literature around mothering to adopt polarised positions focusing on either the "negative aspects of motherhood without focusing on the pleasures that many women experience" (1991:226). At the same time several notable attempts have been made to move beyond ideologies and to try to gather women's own accounts of their transition to, and experiences of, becoming mothers and doing mothering work (Oakley 1979; Oakley, 1980; Boulton, 1983; Brown & Harris, 1978; Richardson, 1993; MacIntyre, 1981). In research terms this involved shifting the focus from the public to the private sphere, an area which until that time had not been regarded as being of 'mainstream' academic interest (Davidoff, 1990; Stacey, 1981; Ribbens and Edwards, 1995).

In her research on transition to motherhood carried out in the mid 1970's, Oakley interviewed women on four separate occasions both antenatally and postnatally. The majority of the women interviewed reported experiencing contradictions "between the idealised view of motherhood as a naturally happy state and the lived realities of being a mother" (1993:128). In another study carried out by Mary Boulton (1983) fifty married women with at least one child not yet at school were interviewed. Boulton found that although some women reported finding the work of childcare enjoyable, a high proportion did not. For these women motherhood was an exhausting, at times frustrating and unsatisfactory experience. These findings - that the lived experience of mothering does not always resonate with the idealised notion of motherhood - and that being a mother can be a depressing experience, were also echoed in Brown and Harris' work (1978). This classic study of working class mothers of young children found that approximately one third of the women interviewed were clinically depressed (1978). Whilst 'vulnerability factors' were identified in these studies, it is hard to avoid Oakley's conclusion that "there is something really depressing about motherhood" (1993:85).

Ideologies which surround and shape notions of motherhood are then pervasive, dynamic and linked to power. Yet this is not to ignore that women are able to exercise some agency in their lives. However such powerful ideologies reinforce idealised notions of motherhood, overriding individual experience and universalising motherhood which in turn fails to accommodate the diversity which exists in mothering (Collins 1994; Phoenix and Woollett, 1991; Segura, 1994, Garcia Coll et al, 1998). Rothman points to the way in which the ideologies of patriarchy, technology and capitalism are interwoven in contemporary notions of motherhood (Rothman, 1989).

Becoming a Mother in the Late 1990s.

Becoming a mother in the late 1990s is a highly complex experience. Whilst debates continue to surround the place of reproduction and childbearing in women's lives, the context in which childbearing takes place echoes other shifts which have occurred in wider society. The institution of marriage is now less popular and increasingly babies are born to couples who are not married (Social Trends, 1998). Women are 'choosing' to have their first child at a later age, currently 28.6 years and 98% of women 'choose' to give birth in hospital (Social Trends, 1998). The development of new reproductive technologies has also meant that childbearing may be possible for some women who in the past would have remained childless (Stanworth, 1987; Denny, 1996), although debates amongst feminists as to the benefits of such treatments continues (Delphy, 1992; Rose, 1994; Foster, 1995). Changes have also occurred in policy relating to the delivery of maternity services. Women have been redefined as 'consumers' of maternity care, with a 'right' to choice, control and continuity of care (The Winterton Report, 1992). Fathers have also been identified as a new consumer group (Barbour, 1990) and their role throughout the childbearing process, and after, has become a matter of debate (Mitchell and Goody, 1997; Laquer, 1992; Ruddick, 1992).

Wider structural changes have also occurred. Government policies currently under discussion ('Supporting Families', 1998) focus anew on 'family' and the ways in which women can be 'helped' into the workforce, combining their mothering with paid work outside the home (this is discussed further in Chapter 9). Whilst such policies carry ambiguous messages about the place of mothering work in the home, they also challenge notions of motherhood and strike at the core of the debates which have divided feminists (and non feminists) over the past thirty years. As Oakley has commented, the contradictory perceptions which surround motherhood make it "a prized and

necessary occupation - yet at the same time it is the most socially undervalued occupation of all" (1981:94). In her paper 'Rethinking feminist attitudes towards motherhood', Gieve draws a distinction between the world of work and childcare. She argues that mothering is not work in the sense of economic and other outcomes, but rather a particular type of 'relationship'. Gieve argues that "the analogy of work has both uses and dangers, but most significantly it fails to encompass those aspects of mothering which make it so difficult for feminists to accept that role. It is the relationship of being a mother which is so challenging to your identity" (1987:42).

Writing in response to the most recent government policy changes, Phillips - adopting an extreme position - has claimed that New Labour policies are "explicitly anti-motherhood, anti-marriage and anti-child" (1998). What is clear is the shifts in policy do challenge a particular strand of feminist argument, that of women's privileged connection with children, or what Delphy has referred to as "maternal demand" (Delphy, 1992:12). Indeed it could be argued that women will now be able to share in the public world of employment, that they will no longer be 'oppressed' by their location in the domestic and private sphere of the home. In reality such policy shifts are not ideologically driven so much as economically grounded. The increased childcare which has been promised will almost certainly be provided by women, leading to many women finally being paid for an *ad hoc* arrangement that has existed for generations - caring for each others children. The context then in which women become mothers in the late 1990s has changed and will continue to change, just as feminists will continue to debate the liberating and/or oppressive dimensions of mothering and challenge ideologies of motherhood. The powerfully interwoven biological and social dimensions of motherhood will ensure that it remains "contested terrain" (Glenn,1994:2).

The location of motherhood within a biological and 'natural' setting has been argued to deny women an identity outside mothering and in so doing locate them within the 'family' (Oakley, 1979; Glenn, 1994; Romito, 1997; Garcia Coll et al, 1998). The "important engendering experience" that motherhood is "in terms of individual identity" has been noted by Fox and Worts (1999:326). The identity of 'mother' then is an overriding one and yet women's experiences of the ontological dimensions of mothering will vary greatly (Boulton, 1983; O'Connor, 1993; Phoenix and Woollett, 1991; Treichler, 1990; Bailey, 1999). As noted earlier, Collins (1994) has pointed to the failure in much feminist theorising to acknowledge the importance of race and class in experiences of motherhood. Commenting on the importance of theorising women's differences, Woollett and Phoenix caution that failure to do so "helps to maintain the status quo as 'normal mothers' being white, middle class, married women and other mothers being deviant/ aberrant" (1991:226).

And yet women continue to become mothers and 'to hold images of what motherhood and childhood should be like' (Ribbens, 1998:28). Having been socialised into roles which anticipate mothering (Abbott and Wallace, 1990) a majority of women, at some time in their reproductive lives, become mothers. Indeed in our society to choose to remain childless is perceived as somehow 'unnatural'. As Romito has noted, "voluntarily childless (or childfree) women feel uneasy about admitting they are happy without children" (1997:172). So whilst many women continue to anticipate having at least one child during their lives, studies have shown that women's expectations of motherhood often do not resonate with their experiences (Oakley, 1993; Richardson, 1993; Mauthner, 1995; Nicolson, 1998; Smith, 1994; Barclay et al, 1997). Indeed, Oakley has argued that "in a patriarchal,

family oriented culture, women come to motherhood with quite unrealistic expectations" (1993:89).

Experiences of transition to motherhood then will be mediated by a multitude of factors including social class, culture, age, and religion (Collins, 1991; Phoenix and Woollett, 1991). In Britain in the late 1990s women becoming pregnant are "exposed to a variety of ideas about pregnancy, childbirth and childcare" (Phoenix and Woollett, 1991:66/67). 'Preparation' for motherhood is located within a highly developed system of preventive antenatal care which is clearly located within a bio-medical context - that is the clinic and hospital (Miller, 1995; Graham and Oakley, 1991; Oakley, 1993). Indeed it is interesting to note that given the diversity of women's lives, services around childbirth continue to be provided in a particularly 'uniform' way (Treichler, 1990). Postnatal care is much less highly developed - and is operationalised within the clinic *and* the private sphere of the home (Garcia and Marchant, 1996; Glazener, MacArthur and Garcia, 1993). Within the National Health Service maternity services are free at the point of delivery and available to all British citizens. And whilst maternity service provision echoes the inverse care law thesis - that where need is greatest, provision is often poorest (Tudor Hart, 1971) - all women are entitled to, and *expected* to access antenatal care during pregnancy. Even before the birth of a child, women begin to be defined in accordance with notions of 'good' mothering (Urwin, 1985). They are expected to prepare appropriately - attend antenatal classes, wear appropriate clothing, change socialising patterns and behaviours to conform to some 'ideal type'. Beyond regular antenatal visits, women and their partners are invited to attend parentcraft classes in order to *prepare* appropriately for parenthood. Yet the cultural location of such preparation is clearly demonstrated in the following extract from a study focusing on take up of antenatal care amongst Bangladeshi women living in

Oxford (Miller, 1995). When asked about attendance at parentcraft classes one respondent replied "that is what most mother-in-laws doesn't like, they said 'why so much bothering?' you have to go and practice...I think that's not necessary, because our culture is so different, we do learn so much from our mum" (1995:307).

Medical regulation and supervision of women are characteristics of the antenatal period of childbearing (Nettleton, 1995, Urwin, 1985, Oakley, 1993), yet the medical gaze switches swiftly from the mother to the baby in the postnatal period. Urwin has noted that the focus of early postnatal check-ups "is almost entirely on the baby, or the mother in relation to the baby; her independent status as a woman is discounted" (1985:177). The development and introduction of the Edinburgh Postnatal Depression Scale (see Appendix 1) is a relatively recent attempt to assess women's mental state in the early weeks following childbirth, and is currently being used in some health regions (see Appendix 2). The questionnaire is administered by a health visitor and women are asked to tick boxes according to how they have felt over the preceding seven days, responses are then coded and a 'diagnosis' made. Whilst this initiative can be welcomed as an attempt to collate women's experiences of early mothering, it is a blunt instrument with which to gather sensitive material and questions have been raised about its usefulness (Barker, 1998). Indeed it can be seen as a further attempt to medicalise and, in turn, problematise normal reactions to becoming a mother. At approximately 6 weeks then following the birth of a baby, a mother is required to attend a medical examination in order that her physical state can be assessed and her future method of contraception ascertained. Once this has been satisfactorily achieved, the close supervision and regulation (surveillance) experienced since the confirmation of pregnancy in most cases ceases. Any 'feelings' which are placed as secondary to 'medical knowledge'

in the antenatal period are now expected to come to the fore: women should 'naturally' know how to be mothers. Whilst women may be socialised from birth into what may be described as 'female' roles, the experience of becoming a mother may not resonate with earlier expectations. The dominance of the biomedical narrative in the antenatal period can be seen to be potentially disempowering. As Lupton has commented, this "situation encourages the pregnant women to be distant from the process, to hand over control of her body to others and to take advice, which may make it difficult to take back control after the birth, when she may have no real knowledge of her own feelings, or her baby" (1994; 148-149). To measure the outcome of pregnancy and childbirth then in terms of mortality statistics, whilst arguably important, is to ignore the significance of the life event of childbearing for the women themselves and the impact of the experience on their lives and their self identity (Smith, 1992; Thompson et al, 1989; Barclay et al, 1997; Bailey, 1999).

Concluding Discussion.

The period of transition from conception to motherhood is then both a very publicly defined affair and simultaneously a very private experience. Childbirth and becoming a mother lie at the interface between the biological and the social. Public definitions of these events often revolve around biologically determinist rhetoric - that women naturally know how to, and want to, be mothers. When and if women find that aspects of their own experiences do not fit with public or even private 'knowledges' that surround and shape perceptions of childbirth and motherhood, the pressure for conformity may be so great that they perceive disclosure as too risky and withdrawal from social networks may result (Mauthner, 1995). Woollett and Phoenix have crucially noted the problematic "nature of motherhood as experience and development which is mainly lived out in a private, domestic

sphere, but which is evaluated within the public domain" (1991:217). The stakes then can be high for those who admit to personally experiencing something other than this public account. Self disclosure may be perceived as too risky in a society where motherhood and family life are all about being a moral person. Paradoxically, the very act of not voicing difficult experiences helps to perpetuate and maintain the myths which surround motherhood. Yet the importance of producing a coherent and acceptable narrative may be experienced as paramount.

In her recent review of feminist scholarship on mothers and motherhood, Ross (1995) notes the shifts which have occurred around their study. She concludes that "motherhood in all its range and complexity is in the process of moving from the margins to the centre of feminist discussion, the mother increasingly a subject rather than a distant, looming object" (1995:413). Woollett and Phoenix (1991) had previously noted the lack of literature on women's own experiences of mothering, commenting that "women's experiences as mothers, their insider perspectives, are rarely examined" (1991:217). In the intervening years research has begun to address this gap (Barclay et al, 1997; Smith 1994; Fox and Worts, 1999). Yet the identification of the 'range and complexity' of motherhood (Ross, 1995), necessitates that research is undertaken from a range of theoretical and methodological perspectives. However if the focus of the research is to be on the mother as subject, on their insider perspective, then an approach which can offer an opportunity for private experiences to be voiced seems most appropriate.

Transition to motherhood then sits at the interface between the biological and the social. Childbirth results from a biological process and yet the contexts in which women live their lives as mothers are socially

constructed, historically specific and culturally varied. Women's experiences of motherhood will be diverse and fragmented: mediated by sociocultural factors such as class and 'race' (Collins, 1994; Glenn, 1994). In contrast, ideologies which surround motherhood are rooted in assumptions of biological determinism and the inevitability of women's destiny to be mothers. Motherhood is seen as unproblematic, a universal category. Becoming a mother is both anticipated and experienced between this "double landscape of inner and outer worlds" (Mattingly and Garro, 1994). My research interest then is concerned to explore how women negotiate and narrate their transition to motherhood, how they *make sense* of becoming a mother for the first time.

Chapter Two

Narrative.

Introduction

The movement away from attempts to explain and understand human action in terms of law-like generalisations and universalities has become an acknowledged 'tradition' within Sociology (Giddens, 1991; Griffiths, 1995; Plummer, 1995). Whilst a "fascination with the possibility of certainty and objectivity" (Griffiths, 1995:56) can still be found in writing influenced by Descartes, Locke, Hume and Kant, the epistemological stance emanating from such a position has been increasingly challenged (Geertz, 1973; Stanley and Wise, 1983; Harding, 1991). The notion that the nature of social reality is not given, but rather bound up with our knowledge of it, was expounded in the work of Berger and Luckmann (1967). More recently the shift away from a quest for certainty and objectivity has been mounted by postmodernisms, post-structuralisms and feminist epistemologies (Stanley, 1990a, Stanley 1990b; Stanley and Wise, 1983; Griffiths, 1995; Edwards and Ribbens, 1995; Ribbens and Edwards, 1998; Aldridge, 1993; Fox, 1993). Challenging claims to truth which have been seen to represent "the experiences of white Western males (or of late, white, middle class, first world feminists)" (Aldridge, 1993:53) has led to a reconsideration of epistemological issues and the production of knowledge. The development of alternatives to traditional epistemologies has emanated from a variety of perspectives, and amongst these, feminists have provided a range of possible epistemologies (Braidotti, 1991; Stanley, 1990, 1991; Stanley and Wise, 1993). Whilst it is clear "that there is no such thing as a definitive feminist epistemology" (Griffiths, 1995:58), Griffiths tentatively proposes that some common threads can be discerned. The most important of these, in this context, is the recognition that "knowledge must be grounded in individual

'experience', 'perspectives', 'subjectivity' or 'position in a discourse'" (1995:61). Issues of power are also of fundamental concern in feminist epistemologies together with the need to recognise that knowledge is itself subject to change (Griffiths, 1995). A focus on individual experience and subjectivity is then central to the challenges made to traditional epistemology. Calling for 'ontologically and grounded' knowledge Stanley and Wise (1993) emphasis the crucial importance of 'human social experience', "being or ontology is the seat of experience and thus of theory and knowledge" (1993:192). Indeed a shift to focus on self identity and the reflexive self is clearly discernible in recent writing within the social sciences (Bruner, 1995; Giddens, 1991; Corradi, 1991; Josselson and Lieblich, 1993; Reissman, 1989; Griffiths, 1995; Birch, 1997). As Bury (1997) has observed, there has been "a general cultural trend in late modern societies to become more 'reflexive' in character" (1997:10). Hand in hand with this shift has been a concern with "making the subjective experience of the self intelligible" (Griffiths, 1995:76).

A focus on different 'ways of being' and 'ways of knowing' in both 'public' and 'private' contexts then has become a concern of social scientists and others in the late 1990s (Stacey, 1981; Ribbens and Edwards, 1995; Edwards and Ribbens, 1998; Collins, 1994; Stanley and Wise, 1983,1993; Stanley, 1990). One version of an attempt to explore how social identity and in turn social action are constituted and guided, has been through the study of narrative¹. As Stephenson asserts "the turn to narrative is a turn away from

¹Polkinghorne (1988) argues that "'narrative' can refer to the process of making a story, to the cognitive scheme of the story or to the results of the process" (1988:13). Like many working in the area of collecting individual's experiences, Polkinghorne uses the terms 'narrative' and 'story' interchangeably. My understanding and use of the term 'narrative' differs from that of 'story', although there is clearly overlap and I acknowledge that both can be seen as devices for challenging taken-for-granted assumptions. Narrative is used in my work to represent the ways in which individual's make sense of, and present a particular self, in particular circumstances and how this changes *over time*. One of the distinctive features of narrative is the temporal ordering of events and *reordering* of events, and the

the search for universal foundations or timeless truths" (1999:122). Although the 'nature and significance of narrative' has been debated by different disciplines, there is consensus that "all forms of narrative share the fundamental interest in making sense of experience, the interest in constructing and communicating meaning" (Chase, 1995:1). Some feminists have also claimed that collecting and listening to "women's personal narratives provide(s) immediate, diverse and rich sources for feminist revisions of knowledge" (The Personal Narratives Group, 1989:263).

Traditionally, narrative accounts have been used as a method or form of representation. More recently attempts have been made to overcome the misperception of narrative as a non-theoretical representation of 'events' through the bringing together of identity and action research. Polkinghorne (1988) has asserted that "self identity becomes linked to a person's life story, which connects up the actions into an integrating plot" (1988:151). By linking these two, narrative analysis has enabled sociologists to focus on 'new ontological dimensions' of narrative studies (Somers 1994). Proponents of narrative theory claim that narrativity can help us to understand social life and social practices, but only through the bringing together of social action, historicity, spaciality and relationality; aspects of narrative which, in the past, have been often overlooked (Stephenson, 1999; Polkinghorne, 1988). As Plummer has recently claimed, "a clear narrative moment has now been sensed" (1996:19). Polkinghorne (1988) also notes "that although narratives are ubiquitous, we are just beginning to appreciate their significance for creating and organising our experiences" (1988:184).

context in which narratives are constructed and used strategically. The form of a narrative, which may be multi-layered, is then linked to the meaning making process. However, both Ken Plummer's work, 'Telling Sexual Stories' (1995) and Arthur Franks (1995) 'The Wounded Storyteller' have provided me with useful insights into how people, in different situations, account for experiences in different ways.

Through the construction/ reconstruction of narrative accounts, using devices such as 'emplotment' (Somers 1994; Ricoeur cited in Valdes, 1991; Mattingly, 1994), 'events' are rendered 'episodes' and a life is given 'unity', the agent being 'not only the actor, but also the author' (MacIntyre 1981:198). As Hyden has recently pointed out, in his comprehensive review focusing on illness and narrative, in essence and "common to most definitions of the narrative is an emphasis on the temporal ordering of events that are associated with change of some kind" (1997:50). The themes of 'plot', 'setting' and 'temporal ordering' are often identified as key elements in narrative construction (Stephenson, 1999; Polkinghorne, 1988). However, Plummer in his recent work (1995) argues that "a sociology of stories should be less concerned with analysing the formal structures of stories or narratives and more interested in inspecting the social role of stories; the ways in which they are produced" (1995:19).

In my research, which involves listening to women's accounts of their experiences of becoming mothers, I am seeking to understand how women *make sense* of 'events' throughout the process of childbearing, constructing these 'events' into 'episodes', and thereby (apparently) maintaining 'unity' within their lives. I am also interested in the ways in which narratives are produced and voiced, or indeed withheld, over time. This approach has prompted engagement with ongoing debates around narrative and raises questions about the ways in which accounts of human identity are shaped and (re)negotiated.

The 'Storied' Human Life

The philosophical tradition from which debates around narrative have emanated has been concerned with how human life is 'storied' (MacIntyre, 1983; Ricoeur, 1981, 1991). But whether our lives are *lived* as narratives, or

narrative accounts constructed and reconstructed retrospectively has been a matter of contention. MacIntyre acknowledges that 'human life is composed of discrete actions which lead nowhere, which have no order; the story teller imposes on human events retrospectively an order which they did not have while they lived' (MacIntyre1981:199). Life is not lived as a neat, chronologically ordered series of events, but rather as actors we are able, through narrative construction and reconstruction, to impose some order, some 'intelligibility' on events, retrospectively. A feature of narrative accounts is that they are continuous (although *discontinuity*, or 'chaos' may occur and this will be considered later in Chapter 7) and through the employment of devices such as 'plot' events are woven into an intelligible and continuous story (Ricouer cited in Valdes, 1991). Ultimately the continuous narrative account provides unity in an individual's life from 'birth to life to death' (MacIntyre1981:191).

Such an explanation of narrativity is, however, in danger of reinforcing notions of narrative as a method only of representation. If the more substantive claim, that narrative is in essence an 'ontological condition of social life' (Somers 1994:614), is to be upheld then it is necessary to consider the link between actor and action further. To talk in terms of the construction and reconstruction of narrative accounts implies a distancing of the actor from the action, which does not sufficiently address the notions of '*intentionality*' and '*accountability*'. Crucially, what MacIntyre is concerned to point out is that an actor's behaviour can only be understood when placed within the context of longer and shorter term intentions, that intentions 'need to be ordered both causally and temporally' and that these must be considered within the context of 'settings'. *Accountability* for action is linked to intention: an actor can be asked "to give an intelligible narrative account enabling us to understand how he (sic) could at different times and different

places be one and the same person and yet be so differently characterised” (MacIntyre 1981:202). Narrative history is then rendered 'intelligible' through an understanding of intention. But it must be acknowledged that human life is also unpredictable. The anticipation/ striving for a *telos* may provide a life with a sense of 'connectedness', an end state to work towards, but the unpredictable nature of human life 'renders all our plans and projects permanently vulnerable and fragile' (MacIntyre 1981:98). The potential for *discontinuity* of a narrative account is then ever present. The unpredictable nature of human life however does not mean that human action is inexplicable, but rather that when predictions are made, they must be considered 'vulnerable in the way that all social predictions are' (MacIntyre 1981:101).

The study of narrative had traditionally been associated with literary and linguistic traditions which have been concerned with analysing the formal structures of stories/ narratives and the formation of language and linguistic codes (Propp, 1968; Barthes, 1977; Labov, 1982; Polkinghorne, 1988). A concern of hermeneutics has also been to focus on how human action is given meaning by individuals, as Widdershoven has claimed “from a hermeneutic point of view, stories are based on life, and life is expressed, articulated, manifested and modified in stories...in stories we aim to make clear and intelligible what life is about” (1993:9). In his recent work, Plummer has argued that Sociologists have been late to recognise the significance of narrative and claims that it is only now that stories have “moved to centre stage in social thought” (1995:19). Working from a symbolic interactionist perspective, Plummer asserts his interest in “the social role of stories” as both “symbolic interactions and political processes” (1995:19). Within the social sciences he identifies that different disciplines have, more readily, taken up the possibilities that narrative construction,

through story telling, can offer. Within Psychology for example the potential of narrative/story telling has been recognised and employed in the study of identity (Sarbin, 1986; Gergen and Gergen, 1986; McAdams, 1985) and within developmental psychology (Gilligan, 1982). Yet within medical sociology the link between narrative and making sense of a changing self, has been identified for some time and explored. In research concerned with how people make sense of living with chronic illness, the importance of narrative construction and reconstruction has been highlighted (Bury, 1982; Williams, 1984; Kleinman, 1988; Waitzkin and Britt, 1993; Mattingly and Garro, 1994). Chronic illness has been conceptualised in terms of 'biographical disruption'² (Bury, 1982) and studies have focused on the implications of this for self identity (Bury, 1982; Williams, 1984; Reissman, 1990; Frank, 1995). In seeking to understand how individuals make sense of disruptive or transitional events in their lives the role of narrative retelling has been recognised as an important enterprise in which individuals "actively shape and account for biographical disruption" (Reissman, 1990:1196).

Yet it is also important to acknowledge that narrative construction does not take place in isolation, but people 'make sense' of what is happening to them in relation to past events and future expectations and in relation to other actors; narratives then are *interpersonally* constructed. Somers (1994) claims 'that stories guide action', that people are guided to act in certain 'acceptable' ways by reference to 'an ultimately limited repertoire of available social, public and cultural narratives'. The notion of 'tradition' is also important in guiding the actions of individuals (MacIntyre 1981). Actors then are apparently limited in their narrative construction/reconstruction, for as Somers points out, "what kind of narratives will socially predominate is

² A critical reassessment of the concept 'biographical disruption' in relation to chronic illness provides the focus of a recent paper by Simon J. Williams ('Sociology of Health and Illness', forthcoming).

contested politically and will depend in large part on the distribution of power” (1994:629). The notion of 'privileged accounts' and 'competing counter narratives', in relation to childbirth research, will be explored later.

Narratives then 'exist' both *internally* and *externally* - they are the individual 'stories' emanating from personal experience (and being reinterpreted/reconstructed over time and in different contexts) and also the collective 'stories' of discernible groups in wider society. An example of this is given by Mishler (1984) writing within a medical context. He has drawn a distinction between 'voices' which can be discerned in medical encounters - the 'voice of medicine' and the 'voice of the lifeworld'. For Mishler, the 'voice of medicine' encompasses the technical details of disease and treatment, whilst the 'voice of the lifeworld' encompasses the social relationships and experiences of the individual. Yet the identification of particular voices or narratives is a complicated enterprise as Barthes (1977) emphasises "the search carried out over a horizontal set of narrative relations may well be as thorough as possible, but must still, to be effective, also operate 'vertically': meaning is not 'at the end' of the narrative it runs across it" (1977:87).

Narratives then are not only multi layered and open ended, but must also be considered contextually and temporally (Stephenson, 1999). The importance of the 'cultural embedding' of a narrative account has also been emphasised in the work of MacIntyre (1981) and Ricouer (1991). Similarly Barthes (1977) has written of the socio-cultural context in which narratives are constructed/ reconstructed and acknowledges the importance of “reference to an implicit system of units and rules” (1977). In his work on illness narratives, Kleinman (1988) has also emphasised the importance of 'belief systems' which are reflected in narrative accounts. The production of 'counter narratives' (Somers 1994) and 'new narratives' (Weeks 1998) have also been

explored in relation to those who find their individual (or minority) experiences are not accommodated within more 'mainstream' narratives.

The Narrative Project:

The shift away from universal notions of agency to a focus on particularistic identities, which has occurred in some areas of the discipline of Sociology, is clearly contested terrain. The increasing interest in narrative and the narration of experience by subject is also a matter which has generated debate (Chase, 1995; Josselson, 1993; Gubruim and Holstein, 1995; Atkinson, 1997; Birch, 1997; Stephenson, 1999). As described earlier, the collection and analysis of narrative data has characterised much work within medical sociology and has only more "recently moved centre stage in social thought" (Plummer, 1995:19). A focus on narrative and story telling can be increasingly discerned in a wide range of disciplines and settings. Atkinson (1998) notes that "we have entered the age of narrative" and goes on to claim that "story presents us with a form of knowing that is equally of interest to history as it is in literature as it is in psychology, sociology and even science" (1998:74).

The narrative enterprise within medical sociology has sought to explore - and make public - accounts of private experience of chronic and other illness conditions. In so doing, previously unheard or unexplored experiences are rendered public and provide an alternative and different perspective on 'illness'. And yet this has not always been the case as Frank (1995) notes in his review of illness in 'modern' (as opposed to post modern) times. In drawing a distinction between modern and post modern times, Frank argues that the modern experience of illness involves "a circulation of stories, professional and lay, but not all stories are equal. The story of illness that trumps all others in the modern period is the medical narrative" (1995:5).

However the distinguishing factor in post modern times - and distinct from modern times - is the need to be able to 'voice' experience. "The post modern divide is crossed" according to Frank "when people's own stories are no longer told as secondary but have their own primary importance" (1995:7). Fox (1993) in a similar vein, has claimed that "although doctors have the privileged stories in Western culture, they are by no means the only people who produce such narratives" (1993:113). Clearly different perspectives can be seen as potentially challenging to dominant, medically located, narratives.

Atkinson however questions the claims that are made by some using a narrative approach to explore personal experience. In his article 'Narrative Turn or Blind Alley' (1997) Atkinson points to the dangers inherent in an approach which attempts - as he sees it - "to privilege certain ways of experiencing over others" (1997:333). Attempts to capture and explore biographical accounts of illness experience are then underpinned by a 'recuperative' project. The danger of this according to Atkinson, is that the goal becomes "therapeutic rather than analytic" (1997:335). Ultimately then the misuse of narrative Atkinson fears, will lead to a new variant of social actor - "the isolated actor who experiences and narrates as a matter of private and privileged experience" (1997:335).

Clearly then the narrative enterprise sits in stark contrast to universalistic notions of instrumental rationality. Yet a focus on narrative construction around a particular life event can make visible (and public) experiences which may hitherto not have been considered of academic interest or 'value', and whilst "any simple celebration of difference or particularity for its own sake" is not enough (Nicholson, 1990:10) focus on an individual narrative should not be dismissed because it is the account of an 'isolated actor'. Whilst narratives may be collected as individual accounts and analysed as

such, this does not preclude a search for “meaningful subsets of experience” *across* and *between* accounts (Atkinson, 1998; Mattingly and Garro, 1994). Research with a longitudinal component can be seen to further facilitate this process. As Robert Atkinson asserts “a particular life story, or a group of life stories, could lead us to generalising or maybe even building a theory of how people see their own lives” (1998:73). Collecting and analysing narratives of private experience and placing them in a public arena can then offer a way of making “visible a different, alternative social and cultural order within which to define our identity and subjectivity” (Edward and Ribbens, 1998:13).

Paul Atkinson’s claim that narrative projects too often “take on an almost therapeutic and emancipatory aspect” (1997:334) and that the goal too often is therapeutic rather than analytic raises a much more perplexing dilemma. The use of qualitative methods to increasingly research sensitive and private aspects of people’s lives - and the specific use of narrative - raises several issues. By creating a space in which participants are invited to narrate their personal experiences the boundaries between doing sensitive feminist research and what other experts do - counselling and therapy - can become blurred (these issues are further discussed in Chapter 8). Participants may use the interview setting to reveal and/or reorder past events in ways which, at times, may place the researcher in the role of counsellor / therapist - indeed the very act of *making sense* of personal experiences involves organising past, present and future events into a coherent narrative (MacIntye, 1981). And whilst ‘empowerment’ (Atkinson, 1997) or ‘therapeutic pay offs’ (Brannen, 1993) may be experienced by the participant, the researcher does not enter the interview with the *aim* of assisting participants in the reauthoring/reordering of their stories. Crucially then the research encounter is entered into with different aims and objectives to those of the therapist.

Narrative Dimensions in Longitudinal Childbirth Research:

In calling for a reframing of narrative, Somers identifies four dimensions of narrativity; 'ontological', 'public', 'meta' and 'conceptual' (1994). Ontological narratives are those used by social actors to define who they are, they are *individually* held narratives, although resulting from interaction with others. Public narratives are those held by units larger than the individual. Meta narratives refers to the 'traditions' in which we are 'embedded as contemporary actors in history'. The term conceptual narrativity involves the development of a 'social analytic vocabulary' through which recognition be given to "the contention that social life, social organisations, social action and social identities are narratively...constructed through both ontological and public narratives" (Somers 1994:620). In seeking to explain, to make sense of, or possibly to make predictions about an individual's actions, or the collective actions of a group of actors, these narrative dimensions must be explored further.

In my research I am exploring how individuals develop and construct meanings around a professionally defined, but personally experienced transition - how women make sense of becoming mothers for the first time. The event of childbirth and process of women becoming mothers has major significance for individual biographies and is also publicly defined. During this period of transition, women are confronted with an array of 'public' (medically/professionally defined), and 'individual' (lay/informal) narratives. Yet unlike some other life events, transition to motherhood is surrounded by pervasive ideologies which can be clearly discerned before, and long after, a child is born. It sits at the interface between the biological and the social, and it is this unique positioning which can influence how women *make sense of*

the event and whether and how they are able to organise their experiences into a 'coherent' narrative.

As the focus of my research is on the process of what is publicly defined as becoming a mother (i.e. a process spanning both antenatal and postnatal periods defined by the medical profession), I needed to design the research so that in depth interviews could capture the events and episodes as the women's experiences unfolded. If 'conversations in particular' and 'human actions in general' are presentations of 'enacted narratives' then a methodology which could capture these was needed (MacIntyre 1981; See Chapter 3 'Methodology'). I have therefore interviewed women on three separate occasions, once antenatally and twice postnatally over a period of a year. Any attempt to 'capture' an individual's narrative account before and after an event (e.g. childbirth) will be problematic. As MacIntyre makes clear "what is true is that in taking an event as a beginning or an ending we bestow a significance upon it which may be debatable" (1981:197). But this is not to imply that an attempt cannot be made to explore how women construct and *reconstruct* narrative accounts around the event of childbearing, rather that their narratives can only be explored within the context of other 'influences'. The use of narrativity then, as a tool of exploration, demands that any understanding of an account is made in relation to its "temporal and spatial relationship to other events" (Somers 1994:616). The link can also be made here to MacIntyre's argument for the acknowledgement of the crucial influence of 'tradition' and its impact on an individual life, that is "the narrative phenomenon of embedding" (MacIntyre 1981:207). Yet traditions are not static, but subject to change. Indeed the shift in place of birth, from home to hospital and the medicalisation of childbearing can be seen to have repercussions for the ways in which women construct/reconstruct narrative accounts around childbearing.

The placing then of childbearing into an illness setting i.e. the clinic and the hospital, and the dominance/privilege of the public (medical/professional) narratives over that of the individual's narrative in the antenatal period has implications for longer term narrative construction/reconstruction. MacIntyre has written of the need for our individual and social lives to continue intelligibly, for the *continuity* of a narrative account (1981). But through periods of transition this may be difficult to maintain. The life event of childbearing, although providing a *telos*, is also a period characterised by *uncertainty* and *unpredictability*, a time when longer and shorter term intentions may have to be continually reviewed. During the antenatal period women are exposed to the 'public' (medical/professional) narrative of childbirth, which is represented and replicated by doctors and other health professionals. This 'public' narrative may or may not resonate with the individual experiences of the women themselves. The potential for a clash between individual narratives, and public narratives (which may indeed be more privileged) is then ever present.

'Capturing' Women's Accounts.

'The capturing of an individual's narrative account then has methodological implications (see Chapter 3). In their work on cancer narratives, Mathieson and Stam (1995) have drawn a useful distinction between 'conversations' and 'narratives'. Conversations become narratives they argue "when they are part of the quest for personal identity. Of the many stories we tell it is those which are ours, not only about us but by us, that have the most meaning to who we are, where we have been and where we intend to go" (1995:284). Narratives then become an important device through which sense can be made of events in a life (Mathieson and Stam, 1995). Using the techniques of qualitative research then, women can be invited to tell their own stories, and

their narratives can be explored. How they make sense of a particular 'event' in their lives, in the context of other narrative influences can be considered in relation to identity and social action. Yet what I had not anticipated in my research was the complexity of the narrative enterprise. At one level, asking women to speak about their experiences of becoming mothers, and listening to their accounts, seems straightforward. Yet it is because the event of childbirth and becoming a mother is both highly significant for private lives and personal biographies and, simultaneously, a very publicly defined affair, that difficulties are encountered. Narrative accounts are then multi-layered and complex, comprised of public, lay and sometimes personal ('counter') narrative threads (Miller, 1998).

Whilst the narrative dimensions proposed by Somers (1994) have been influential in the course of planning my research, the process of data collection and analysis have led me to focus on the production of what Somers labels 'counter narratives' and what I have come to refer to as 'personal narratives' (Ribbens and Edwards, 1998; Miller, 1998). The production of 'counter narratives', according to Somers, becomes 'a crucial strategy when one's identity is not expressed in the dominant public ones' (1994:631). I have used the term 'personal narrative' to describe the sense of self in an individual's account which does not fit with either public or private narratives and which may challenge or contradict both. The link between narrative and a sense of self according to Stephenson (1999) is "achieved through our capacity to conceive of our own lives as a unity and this in turn is a result of our capacity to tell the story of our lives" (1999:117). Yet the *changing* nature of the sense of self - 'the fragmentations and the coherences of self' (Stanley 1993:207) must also be acknowledged, as Polkinghorne notes, the self "is not a static thing nor a substance, but a configuring of personal events into a historical unity which includes not only

what one has been but also anticipations of what one will be" (1988:150). Clearly then the presence of a 'personal narrative' in a research account, distinct from those emanating from the public or lay knowledge's surrounding childbirth raises questions about whether and how women feel able to voice their own personal experiences (Miller, 1998).

My research has been concerned with following women through a period of significant transition in their lives. Antenatally women construct accounts which are characterised by reference to public and lay narratives - to what Somers would call the 'limited repertoire' of 'acceptable' narratives which surround childbirth. Yet once the child is born, during the early stages of the postnatal period, the 'public' (medical/professional) narrative, which has been, in a very real sense, 'embodied' and perpetuated by some health professionals may be almost completely withdrawn and the new mother's account of her experiences is constructed with reference to more informal 'lay' narratives, *interpersonally* constructed with reference to family, friends, mothers and sisters. But what happens when a new mother cannot locate her experiences either within the realms of 'public' or 'lay' narratives, when she finds that her experiences do not appear to fit with those of others? The potential for *discontinuity* of an individual's narrative account may be paramount at this stage. Having been 'guided' and supported by the 'symbolic resource' of the bio-medical model (Bury 1982) in the antenatal period, the new mother finds she must be guided by her own 'instincts', her individual narrative, which may have been denied (or at least relegated) antenatally. The dominance of the bio-medical narrative in the antenatal period can be seen to be potentially 'disempowering'. The public narratives which surround antenatal preparation for childbirth, can be seen to induce a sense of the *predictability* of childbearing. When postnatally 'mothering' is found to be *unpredictable*, an individual's narrative may become *unintelligible*. In a very

real sense, the 'plot' may be lost as a mother attempts to make sense of the changes she is experiencing. Problems then can arise when an individual's experiences cannot be accommodated within the available range of multi-layered public or lay narratives, and as Somers states, 'struggles over narrations are thus struggles over identity' (1994:631).

If women find that aspects of their own experiences do not fit with the public or even lay 'knowledges' that surround and shape perceptions of childbirth and motherhood, the pressure for conformity may be so great that they perceive disclosure, of experiencing something different, as too risky. Public narratives of childbearing may reinforce the biologically-determinist rhetoric that women *naturally* know how to, and want to be mothers. The stakes then can be high for those who admit to personally experiencing something other than this public account. In the accounts I have collected, over the course of 49 interviews, the 'personal' is, at times, clearly discernible - women begin to express *their* feelings and experiences which may not fit with more public or lay accounts. In others, the women's experiences have either apparently resonated with the predominant public narratives, or have been supported by lay accounts (from mothers, sisters, friends etc.), or the women perhaps have not felt comfortable enough with me to share their personal experiences and voice their feelings (these issues are discussed in Chapter 3).

Concluding Discussion

As human actors our lives are storied and given continuity and wholeness through narrative construction/reconstruction. Through the linking of social identity and social action the ways in which individual's narratives are constructed can be explored. The capturing of individual narrative accounts, and potential for subsequent theory generation, is underpinned by the recent

shifts in sociologies of action which focus on 'particularistic identities' rather than 'universal notions of agency' (Somers 1994:634). Crucially, narratives must be considered within the context of time and tradition, and in terms of an actor's relational setting. However, whilst a focus on narrative (re)construction offers a method through which women's experiences of transition to motherhood can be explored and (ultimately) theory generated, the enterprise is a complex one. Because the period of transition to motherhood is both a public event and a private experience, positioned at the interface between the biological and the social, the production of a 'coherent' and continuous narrative may be difficult for a new mother to maintain. Whilst the importance of the *continuity* of a narrative account - through the ordering of events into coherent episodes - has been stressed, some women may find that their experiences do not fit with theirs, or others, expectations. They may encounter difficulties in *making sense* of their experience of transition to motherhood. In attempting to capture women's accounts of their transition, it has been necessary to consider the limited repertoire of 'acceptable' public and lay narratives which surround childbirth and the effect of these on whether and how women feel able to voice a counter 'personal' narrative. Ultimately it is hoped that a focus on narrative construction around the life event of childbearing will bring into relief the potential for disjunction experienced by women during this intensely private, but also publicly defined event.

Chapter Three

Methodology.

Introduction.

The debates around questions of epistemology have occurred within the context of a society in transition, from 'late modern society' to a 'postmodernist' society. Within this transformation, attempts to understand and explain human action through the verification or falsification of hypotheses and the drawing up of law like generalisations have increasingly been questioned and abandoned. Similarly, the perception of research as a tool for testing hypotheses has been rejected by many (Gubrium and Holstein, 1995; Josselson and Lieblich, 1993; Denzin and Lincoln, 1998; Stanley, 1990; Ribbens and Edwards, 1998). One version of this rejection of hypothetico-deductivism in the study of human action has led to the consideration of how social identity and, in turn, social action are constituted through, and guided by, narrative (Somers, 1994; MacIntyre, 1981; Ricoeur, 1981,1991; Plummer, 1995; Kleinman, 1988; Frank, 1995; Mathieson and Stam, 1995; Gerhardt, 1991; Gergen and Gergen, 1986; Sarbin, 1986; Hyden, 1997; Birch, 1998). Through a refocusing on epistemological and ontological issues, researchers have increasingly sought to understand human action through the collection of individuals own accounts of their experiences (Bury, 1982; Williams, 1984; Gerhardt, 1991, 1996; Reissman, 1989,1990; Miller, 1998; Mathieson and Stam, 1995; Frank, 1995; Cornwell, 1984; Waitzkin and Britt, 1993; Mattingly and Garro, 1994; Edwards and Ribbens, 1998). A focus on subjective experience has led to an increased interest in the role of story telling as a narrative form. According to Chase, "taking narrative seriously means directing our attention to that process of embodiment, to what narrators accomplish as they tell their stories, and how that accomplishment is culturally shaped" (1995:2)

The shift to focus on subjective experience and the meanings individuals give to their actions, has led to a concern with the research process itself and the ways in which data are gathered (Atkinson, 1997; Corradi, 1991; Stanley, 1990, 1993; Cotterill and Letherby, 1993; Chase, 1995, Atkinson, 1998). The need to produce 'useful knowledge' and 'unalienated knowledge' has been emphasised in the work of Stanley and her colleagues at Manchester University¹. The contribution of feminisms more widely to the debate on researching people's lives and the research process must also be acknowledged (Roberts, 1981; Stanley, 1990; Stanley and Wise, 1983; Stanley, 1990; Oakley, 1993; Edwards and Ribbens, 1995; Ribbens and Edwards, 1998; Cotterill and Letherby, 1993). Yet the shift towards inductivism is not without problems. Indeed the dangers inherent in perceiving the research methods associated with hypothetico-deductivism and inductivism, that is quantitative and qualitative methods, as polarised and mutually exclusive must be recognised. The research methods emanating from these research traditions require rigour in their practice, validity of each method being dependent on their appropriate application and systematic employment. The 'doing' of qualitative research does not have to entail adopting a 'totally relativist' stance. As Edwards and Ribbens acknowledge "rather than a relativist despair, we need high standards of reflexivity and openness about choices made throughout any empirical study, considering the implications of practical choices for the knowledge being produced" (1998:4). And whilst the differing philosophical positions and theoretical principles underpinning each approach need to be recognised (Robson, 1993; Geertz, 1973; Denzin and Lincoln, 1998), this should not prevent, where appropriate, the successful combining of methods (Mason, 1994).

¹See for example the collection of writings in 'Feminist Praxis' (1990).

The Research Question.

The idea to focus a piece of research on women's experiences of becoming mothers in the mid 1990s arose from links that emerged between my own private and public 'lives'. Following the birth of my third daughter and several years at home with young children and intermittent studying for a further degree, I re-entered the public sphere with a job as a university lecturer. In that role I teach, amongst others, groups of midwifery degree students. It was a combination of their questions, linked to my own and other friends experiences of motherhood, which led to my present piece of research. The midwives, returning from periods of practice, often shared their frustration at having to leave the women they had formed relationships with, 10 days after the birth of a new baby. Private feelings led these midwives to question their professional roles: it was just at this time that they felt they could offer most practical and emotional support, and at this time too that they perceived that mothers most seemed to need it. I, however, had felt in turns frustrated at the intervention by various health professionals and grateful for the safe delivery of each of my children. I had experienced feelings of elation and desperation, but the overriding feeling was that no one had said it would be like *this*: the lived experience of becoming a mother did not resonate with the 'public' account of what it would be like. And it wasn't only me, other new mothers I met spoke of the unacknowledged hard work of being a mother, of the disparity between what they had thought it would be like, and had been led to believe it would be like during antenatal 'preparation' classes, and their experiences of motherhood.

My autobiography then led to my research interest and indeed the researcher's autobiography can be discerned as a continuous thread running through all stages of the research, from research question to research writing. In terms of areas for exploration included in interview schedules,

presentation of self in accessing and meeting research participants and in data gathering, analysis and final write up, the invisible presence of the researcher's autobiography can exert influence and should be acknowledged (Cotterill and Letherby, 1993). This necessitates high standards of reflexivity throughout the research process and openness about the choices that are made.

Research Design

In order to gather women's accounts of their *experiences* of becoming mothers it was necessary to choose a research method which would enable the women's voices to be distinct and discernible (Edwards and Ribbens, 1995). Quantitative methods in the form of pre-structured and pre-categorized questionnaires could not provide the sensitive research tool required. I decided to use qualitative methods, specifically in the form of depth interviews using a semi-structured interview schedule. As the focus of the research is on the *process* of, what is publicly defined as, becoming a mother (i.e.. a process spanning both antenatal and postnatal periods defined by the medical profession), I needed to design the research so that the interviews could capture episodes as the story of women's experiences unfolded. A longitudinal component would mirror the period of transition, giving the data collection period a fluidity not usually achieved in one off interviews. The decision was taken to interview participants on three separate occasions: once antenatally at 7-8 months pregnant, and twice postnatally at 6-8 weeks following the birth, and finally when the baby was 8-9 months old. As the data gathering process unfolded a decision was made to send each participant a questionnaire once the final interview had taken place. This was designed to confirm data on age, education, occupation and to gather participants' own definition of the social class they would place themselves in, and more specifically to gather data on participants'

experiences of being researched (see Appendix 3). The rationale behind the timing of the interviews was that antenatally it was important that the pregnancy was well established and that participants had been exposed to routinized antenatal care. Postnatally the first interview was timed to coincide with the routine 6 week postnatal check of the new mother by her general practitioner and the final interview was timed to elicit as late an episode of the participant's story as possible within the imposed time scale of Ph.D research. In effect the research has been largely defined by reference to the public events in the childbirth process. Similarly, descriptions of the different phases of childbirth rely on public (usually medically defined) language.

The semi-structured interview schedule was compiled initially from a combination of findings from other studies and the areas I identified as potentially relevant. The interview schedule developed by Mathieson and Stam (1995) in their work on identity and cancer narratives was particularly useful and had been designed as a result of theirs, and others, previous work on identity - related issues (Belenky, Clinchy, Goldberger and Tarule, 1986; Stam, Koopmans and Mathieson, 1991 cited in Mathieson and Stam, 1995) (see Appendix 4). After a pilot phase in which 3 depth interviews were carried out, transcribed verbatim and analysed, minor changes were made. These changes involved the inclusion of other areas identified by participants, for example a question relating to perceived ability to cope once the baby was born. The longitudinal aspect of the research involved the development of three separate interview schedules (see Appendix 5). Before returning to carry out the two postnatal interviews, I read the participants' previous interview transcript and issues arising from these were incorporated into the interview schedule (see Chapter 8). At the end of each interview, I asked participants if there was anything they would like to add. Participants

were verbally assured that their names, and those of others mentioned in their interview, would be changed to ensure anonymity in my thesis (and any publications). However I made clear that had I 'faithfully' represented their accounts, they should be able to recognise themselves. The end of study questionnaire contained a question which asked if participants would like to receive "news of findings from the study", all participants confirmed that they would and my intention is to produce a synopsis of findings for them.

Accessing Potential Participants.

As the focus of the research is on exploring how women *make sense* of becoming mothers within the context of an array of public and lay knowledges and personal experiences, the way in which potential participants are accessed becomes an important consideration. The employment of informal snowballing techniques was decided upon to locate potential participants. This decision was based on the principles of not wanting to advertise and so recruit a self-selected sample, nor to recruit through health professional contacts. The rationale behind this latter principle was concern that women recruited through antenatal clinics by midwives/ health visitors might perceive the research as in some way linked to the delivery of health care services and feel inhibited in the ways in which they felt able to talk about their experiences. My concern was that women accessed in this way might feel obliged to present their experiences in a way that mirrored public accounts given by health and medical professionals. I particularly wanted to gather women's own private and personal experiences. The research was at all times guided by the statement of ethical practice contained in the guidelines of the British Sociological Association (BSA, 1993). Had participants been accessed through the more formal channels of a health practice then it is recognised that approval from an

appropriate Health Authority Ethics Committee would have been necessary, and sought.

The question of *how many* participants to include in qualitative research is a recurrent theme at the planning stage of any project - how many people are enough? Because qualitative research is not (usually) attempting to produce 'generalisable results' but rather seeking to collect data arising from individual's experience, the question of 'how many are enough' will vary from project to project. Achieving 'saturation' (Glaser and Strauss, 1967) is one way of deciding when a sufficient sample has been accessed. However this is a decision which can only be made once data collection and preliminary analysis are underway.

Initially it was anticipated that 20 women, who were expecting their *first* child, would be included in the study, the sample to include 10 women from professional backgrounds and 10 from non-professional backgrounds. Because the focus of the research was on the collection and interpretation of narrative accounts - which are culturally embedded - a decision was taken not to include women from minority ethnic groups. Whilst it is acknowledged that these women's experiences are equally valid I, as a white, middle class researcher, did not share the same cultural location which would facilitate interpretation of the data collected. I had previously researched the utilisation of antenatal services by a small group of Bangladeshi women living in Oxford and I was sensitive to the difficulties of access and interpretation - even as someone who had lived and worked in Bangladesh and could speak some Bengali (Miller, 1995; Edwards, 1996). The debates which have taken place amongst feminists about the dangers of adopting an essentialist position had also been noted (Chodorow, 1978; Ruddick, 1980; Phoenix, 1990; Collins, 1994). And whilst I acknowledge

that womens' experiences are equally valid, I recognise difference and the dangers inherent in adopting an approach which minimizes these differences. The context in which lives are lived becomes crucially important in 'situating' accounts. As Collins (1994) has pointed out "for women of color, the subjective experience of mothering/motherhood is inextricably linked to the sociocultural concern of racial ethnic communities - one does not exist without the other" (1994:47). The corollary to this is not to suggest that White women form an homogeneous group, clearly they do not, but that aspects of the 'cultural embedding' of their lives may be more similar.

The research was designed so that each woman would be interviewed on three separate occasions over the course of approximately one year. It was anticipated that these women would be located and accessed through 'snowballing'. Access through 'snowballing' is a widely recognized technique in qualitative research, yet the potential problematic nature of the technique is not often acknowledged. Initially I experienced unexpected difficulties in accessing participants. Later the type of sample accessed and the relationship between 'gatekeeper' and participant became problematic, both affecting whether and how women felt able to speak about their experiences (this is discussed further in Chapter 8). As a starting point for the snowballing I used my own social network, asking other mothers at my children's school if they knew of anyone who was expecting a first child. Two mothers, both acquaintances of mine, responded to this request and eventually acted as 'gatekeepers' to three participants. What I had not foreseen was how slow the process of snowballing could be and how important the gatekeepers would be in the type of sample accessed. In this research the women accessed are predominately professional, working women, reflecting my own social network - but not what I had anticipated at the planning stage of the research. Having made contact with the first three

participants and arranged convenient times for interviewing, I was dismayed to find that far from belonging to a network of other expectant mothers as I had naively assumed/hoped, they knew of no one else who was expecting a first child. Other entry points had to be explored and further gatekeepers had to be recruited. This involved a written request to all technical and academic staff in the university department where I work, asking whether they knew of anyone expecting their first child. An advertisement was also placed in the university Nursery which my daughter attended. This eventually resulted in two more women being included in the study. Having accessed only eight participants over the course of a year, it was at this point that the snowballing suddenly took off - thanks to the efforts of one particular gatekeeper - and I soon had a sample of eighteen women who were expecting their first child. At this point the decision was taken to cease the snowballing and to concentrate on the eighteen women accessed. This decision was based on the sheer amount of data which was being generated over the course of the antenatal and postnatal interviews - which had by now been carried out with some of the earlier participants. Because the focus of the study was on how women *construct* and *narrate* experiences of transition, the longitudinal element of the research, together with the development of a researcher-researched relationship were of greater importance than trying to achieve an arbitrarily imposed sample size.

The importance of re-negotiating access at each stage of a longitudinal study is not always recognised in research. In this study women were informed at the outset that if they wanted to withdraw from the research at anytime, they could. Re-access was negotiated by telephone shortly before the second and third interviews were due. Whilst participants may be willing to partake in a study which seems relevant to their lives - in this case *their* experiences of transition to motherhood - it is because their transition may not be

experienced in ways which they have anticipated, that renegotiation of access becomes crucial. This was illustrated by the experiences of one of the participants who felt unable to be interviewed during the early postnatal period because, paradoxically, she was experiencing the very thing the research was about, the disjunction between expectations and experiences (See Chapter 7).

The Research Encounter.

The interviews were carried out in a location chosen by the participant, or possibly in two cases by the gatekeeper. Most of the women invited me to carry out the interview in their homes, but one gatekeeper arranged that, for geographical reasons, the interviews with the two participants she had introduced me to (her sister and sister-in-law) should take place in her home. The ability of gatekeepers to exert leverage in the research setting has previously been documented (Miller, 1995:303). But the ways in which gatekeepers, through their relationships with participants, can *continue* to exert an influence over whether and how a participant feels able to speak is less well documented. (The potentially inhibiting influence of the relationship between gatekeeper and participant is discussed further in Chapter 8). Once gatekeepers had passed a willing participant's contact details to me, I made contact by telephone. I introduced myself and outlined the context of my research, answering any questions they had. Interviews were then set up at a time and location of convenience to the participant. Having gained permission from participants, the interviews were all tape recorded. The tape - recorded interviews were transcribed verbatim, and at the end of the study the tapes were returned to the participants. The process then of gathering data is, in technical terms, relatively unproblematic. Yet in all other respects the process of gathering data around an event which is publicly defined, yet personally experienced is much more complicated. The

issues of whether and how women are able to voice their experiences are fundamental to the data gathering process. At one level, asking women to speak about their experiences of becoming mothers, and listening to their accounts, seems straightforward. But *self* - disclosure in a society in which motherhood and family life are all about being a 'moral' person, may be perceived as too risky.

The ways then in which research is presented to, and perceived by, participants will also have an impact on what is voiced during an interview. The shift from a pretence of 'value-free objectivity' to acknowledgement of the 'conscious subjectivity' inherent in the research process has led many researchers to rethink the researcher - researched relationship (Finch, 1984; Oakley, 1981; Stanley and Wise, 1983; Ribbens, 1989; Edwards, 1993; Reissman, 1987; Cotterill and Letherby, 1993; Ribbens and Edwards, 1998). Elements of the research process which had previously gone unquestioned are now being scrutinised, reflection becoming a crucial dimension of the research process. Using the very public language of research then, the establishment of 'rapport', and the effect of researcher reactivity will be significant factors in how experiences are voiced. Yet the public language of research should not obscure the private and/or personal experiences and feelings that the researcher takes into the interview, and with which she leaves it, and which may affect the ways in which women's voices are listened to. I acknowledge that I have liked some of the participants more than others (sometimes where an aspect of their biography resonates with my own), and that my public (professional) researcher role and private and personal life are interwoven. Similarly, some of the women in the study will have liked me more than others, and this will almost certainly have affected the ways in which they have felt able to voice their experiences, the ways in which they have constructed *their* story.

The ways in which the researcher is 'placed' will also influence the interview. Whilst an appeal to women's shared experiences (Finch, 1984) can facilitate data gathering because participants are able to identify with aspects of the researcher's biography, it may also inhibit the relationship. In research focusing on aspects of motherhood it is important to consider how advancement in terms of a 'mothering career' may affect the researcher - participant relationship (Ribbens, 1989:585) and the ways in which women feel able to voice their experiences. It is necessary then for the researcher to consider how disclosure about one's self might effect both how comfortable a participant feels and what she may feel able to voice during an interview. Feminist researchers have written of the different practical ways in which they have approached this problem (Edwards, 1993; Cotterill and Letherby, 1993). I resolved at the outset to inform all the participants that I was a mother of three daughters who were now all at school and that I worked part-time outside the home. Yet I found that my self disclosure increased in relation to the phase of the research, so that whilst I was careful to make only neutral comments if asked about *my* experiences of giving birth during antenatal interviews ("everyone seems to experience it differently"), when I returned to interview participants postnatally I found I revealed more about my own experiences if asked. In some ways my decisions about how and what to disclose of my own experiences mirrors the public wall of silence which seems to shroud discussions about pain in childbirth. During one early postnatal interview, I was confronted by the new mother. 'To be honest', she said, 'even you didn't tell me what it would be like'. Clearly she felt that I had let her down. This illustrates the complex interweaving of boundaries that can arise in research, between the public and private in the lives of the researcher and participant. I had clearly colluded with the publicly held silence around pain in childbirth, and in so doing had myself contributed to

the multi-layered knowledges which surround childbirth. Indeed in this case it appeared that I had become part of the public/lay knowledge/s surrounding this women's transition to motherhood. So, whilst I have felt comfortable in sharing certain information about myself, it has also been important that I continually reflect on the potential effect of this disclosure.

A further dilemma which has arisen during the course of my research concerns the ways in which the research encounter can become confused with a therapy encounter. As qualitative research methods have increasingly been used to research more sensitive topics and the 'private' sphere of individual's lives, so the boundaries between research and therapy/counselling appear to have become blurred. In the guidelines Atkinson provides for 'the life story interview' he asserts that "meaning is not necessarily evident in the experience itself, but it becomes much more so when we tell a story about the experience" (1998;74). In research which involves inviting individuals' to voice their experiences of transition - which may involve reordering past events - and to provide a (recognisable) narrative of motherhood, similarities with the therapeutic encounter can be discerned. Indeed inviting clients to reauthor their story, which is then witnessed by a therapist, is a recognised practice in psychotherapy (Birch and Miller, forthcoming).

In the course of my research I have, on occasions, felt uncomfortable when participants appeared to have 'used' the interview as a therapeutic opportunity. Whilst some feminist writers have embraced the possibility that their research can offer "therapeutic pay offs and opportunities for personal growth" (Brannen, 1993), or opportunities to interact with women participants as "counsellor, researcher and women" (Kennedy Bergen, 1993), I have felt some ambivalence when placed by participants in a therapy type

role. My uncertain feelings at this practice derives from a difference that I perceive to exist between the aims and intentions of a researcher when compared to those of a therapist (this is discussed further in Chapter 8). I don't have the professional qualifications that would guide the work of a therapist. Yet by being a careful listener and sensitive qualitative researcher, I necessarily strive to place participants at their ease and invite them to reflect and (sometimes) disclose lived experiences. And whilst I acknowledge that using qualitative methods to research sensitive and private areas of peoples lives raises ethical concerns, I am also aware that my perception of a 'good' interview is one in which some form of disclosure has taken place. The role of the researcher then needs to be continually reflected upon.

Analysis of the Data.

The acknowledgment that social research is a dynamic *process* has led to discussions concerning approaches to data analysis (Bryman and Burgess, 1994), although much published work regrettably omits detail of how, and when, analysis has actually been carried out. Analysis of data in qualitative research can involve strict adherence to the principles of grounded theory (Glaser and Strauss, 1967), although in practice more claims are made to having used grounded theory than actually follow the rigorous steps its employment requires (Bryman and Burgess, 1994). Analytic induction is another 'rigorous' approach referred to in research methods books (Miles and Huberman, 1984). Whether researchers claim to be attempting to generate theory from data, or to be presenting an interpretative and/or descriptive account, most would recognise the need to *organise* the data as an initial step in analysis. Coding of identified categories, and the development of concepts, can follow on from this. But whilst researchers should be explicit about the ways in which they organise, analyse and generate theory from

their data, the fluidity of this process should also be acknowledged. Analysis very often does not form a separate stage in the research process, but is an ongoing element which runs throughout the research process. In qualitative research which focuses on how individual's narrate experiences of transition and biographical disruption the analysis can take a variety of forms. But the overriding aim according to Josselson and Lieblich, is 'the interpretation of experience' (1995). Meaning then is derived through interpretation.

The ways in which narratives are analysed and interpreted, once gathered, has involved different strategies, from an intensive analysis of linguistic codes to the identification of 'meaning units' (Mishler, 1986), and 'narrative genres' (Reissman, 1990) to 'frameworks' which can help to 'disentangle types of narrative' (Frank, 1995). Reissman draws a distinction between the analysis more commonly undertaken in traditional qualitative research and that of narrative analysis which "does not fragment the text into discrete content categories for coding purposes but, instead, identifies longer stretches of talk that take the form of narrative - a discourse organised around time and consequential events in a 'world' created by the narrator" (1990:1195). Whilst narratives may be collected as individual accounts and analysed as such, this does not preclude a search for 'meaningful subsets of experience' across and between accounts, and this has been undertaken. The longitudinal component in research which mirrors a period of transition enables the collection, and subsequent analysis, of narratives *over time*. Essentially then whilst I have been concerned to explore the structure of women's narrative accounts, I have also been interested in the function the narrative they construct serves. Within this the focus of analysis has concentrated on the social action implicit within an account, and the ways in which narratives are 'situated' (Coffey and Atkinson, 1996). Indeed the function served by constructing a narrative in a particular way has become a

primary focus in the detailed analysis: how and when stories of 'success' can be constructed and narrated being a major theme.

The tape-recorded interviews were transcribed verbatim and preliminary analysis was undertaken between individuals' antenatal and subsequent postnatal interviews. Adopting and adapting what Mathieson and Stam describe as "the constant comparison method" (1995:292), "continuous processing of the interviews" was undertaken during, and after, the data collection phase of the research. Subsets of common or contrasting experiences were identified, and concepts developed. In effect the analysis took place in several stages, as first antenatal interviews were completed, and then subsequent postnatal interviews were completed. Preliminary analysis of the antenatal interviews revealed recurrent themes around 'control' and 'responsibility', 'ability to cope as a mother' and 'changing body shape and self' (Miller, 1996). It was also apparent that the participants had willingly engaged with the public (medical, professional) narrative (tradition) of preparation for childbearing and childbirth. The women were able to construct 'coherent' narratives of preparing to become mothers. In contrast the narratives collected in the interviews carried out at between 6-8 weeks postnatally reflected the struggles women were experiencing in trying to make sense of the gap between their expectations and their lived experiences. Analysis of the early postnatal interviews revealed that the narratives being constructed were of a different *type* to those from the antenatal interviews. The final postnatal interviews (8-9 months postnatally) again revealed different ways of narrating experiences of transition to motherhood. In effect then the longitudinal element of the research has led to a prolonged period of analysis with the constant need to revisit earlier interviews. Yet this approach has also enabled the identification of different narrative 'types'. This in turn has led to a focus on the apparent *function* served by producing particular

types of narratives. Once the interviewing stage of the research process had been completed a synopsis of each participants accounts was compiled. The process of managing data and, more fundamentally, making choices about what to focus on and so, by implication, what to 'let go', is also a difficult stage in the research process. Having had the privilege of gathering women's accounts of becoming mothers, *all* the data is of interest to me! Strategic decisions have to be made in any research and I comfort myself with the hope that parts of the data which are not used in my thesis may be used at a later date for different audiences.

Narrative 'Reliability' and 'Validity':

Qualitative research is concerned with exploring social worlds from the perspective of the individual, their 'reality' of their social world. In contrast to research using quantitative methods, qualitative researchers are concerned with gathering 'rich' and 'deep' data. Given the differering epistemological positions underpinning these two approaches, debates in recent years have focused on the 'rigour' of each method. Whilst quantitative methods often involve an attempt to measure phenomenon and employ statistical tests to demonstrate 'validity' of data, such constructs are not relevant to qualitative researchers. As Ely et al. have observed, "the language of positivistic research is not congruent with or adequate to qualitative work" (1991:95 cited in Cresswell, 1999). Yet rigour in qualitative research is essential and decisions made throughout the research process must be made clear at all times. The adoption of terminology which more accurately reflects the naturalistic dimensions of qualitative research, is recommended by Lincoln and Guba (1985). Rather than employ (borrow) the term 'validity', Lincoln and Guba propose that the '*trustworthiness*' of a study can be assessed through consideration of the following: 'credibility', 'transferability', 'dependability' and 'confirmability', and recommend techniques for

operationalising these 'measures' (1985). The qualitative researcher then "looks to confirmability rather than objectivity in establishing the value of the data" (Cresswell, 1999:198). In research which is concerned with collecting narrative accounts of subjective experience, "reliability and validity are not necessarily the appropriate valiative standards" (Atkinson,1998:59). As Reissman has demonstrated, people narrating their experiences of the same event will produce differing accounts (1989) and that these "are always edited versions of reality, not objective and impartial descriptions of it" (Reissman, 1990:1197). The search then is not for any objective, measurable 'truth', but rather as The Personal Narratives Group explain, "the truths of personal narratives are the truths revealed from real positions in the world, through lived experience in social relationships, in the context of passionate beliefs and partisan stands" (1989:263).

Identifying Narrative 'Layers':

As already documented, the focus on 'public' and 'private' areas of our lives has been a focus of feminist writing in recent years, challenging the authority of 'scientific' knowledge and particular ways of knowing (Stanley and Wise 1983; Stanley, 1990a; Stanley 1990b). Yet in research which involves the very *individual* experience of becoming a mother, a further distinction alongside 'public' and 'private' is needed. Whilst in this research the term 'public' refers to the professional definitions of childbirth maintained and practiced by medical and health professionals, and the term 'private' to lay knowledges of childbirth made up of informal interactions between women and their families, friends, mothers and sisters, a finer focus is also needed. The term 'personal' is introduced to represent the sense of *self* in an individual's account which does not fit with either the public or private account and which may challenge or contradict both these professionally

defined and/or lay knowledges² (see Appendix 6). Voicing the 'personal' then involves *self* disclosure in a way that may be felt by some to incur too much risk.

Concluding Discussion.

The period of transition from conception to motherhood is then both a very publicly defined affair and simultaneously a very private experience. Researching women's lives during this period of transition brings the research process itself into focus, yet this is often not acknowledged or scrutinized in any way. The research design, together with how women are accessed, the perceived influence of the gatekeeper and women's own perceptions of me as the researcher - and a mother - are all factors which can and will affect the ways in which women articulate their experiences. Collecting and listening to women's accounts then requires continual and systematic reflection, and openness about decisions made. The data gathered in the course of an interview will contain both the participant and the researcher, it involves collaboration and is a co-production. In turn this necessitates continual reflection on the potential ethical or other dilemmas which this type of research might raise. The research process is often depicted as a neat series of chronological stages which can be logically followed. In practice, doing research is a messy business onto which the researcher retrospectively imposes some sense of order. And in so doing, the hope is that research participants' voices will be retained and heard within the public domain.

²I am grateful to Jane Ribbens and Ros Edwards for suggesting this other setting. In the introduction to their book *Feminist Dilemmas in Qualitative Research* (1998), they make the following comment "in working with the concepts of public and private and in editing this book, we have come to recognize the importance of another dimension within this conceptualization - that of the 'personal' - and how this is linked to the public and private, and to researching the private in order to make it public". They go on to explain that the "personal concerns the social as ontologically experienced by the individual" (see Appendix 6 for diagram and further explanation).

Narrative trajectories: an introduction

Narratives are told with a purpose. Through the construction of recognisable and culturally acceptable narratives, social actors place their experiences, their selves, within the context of wider social groupings and cultural settings. As Reissman has commented "we are forever composing impressions of ourselves, projecting a definition of who we are, and making claims about ourselves and the world that we test and negotiate in social interaction" (1990:1195). Narratives then can be seen to serve a strategic function. A focus on narratives enables the researcher to explore both "individual courses of action and the effects of system - level constraints within which those courses evolve" (The Personal Narratives Group, 1989:6). Narratives may be constructed in such a way that they appear to conform to social norms and expectations, or strategies may be employed to challenge dominant ideologies. The production of 'counter narratives' (Somers, 1994) may be produced by individuals or groups who do not find their experiences are accommodated or embedded within dominant ideologies. The passing of time also enables the possibility for reflection and the reordering of events into narratives which are differently plotted.

Transition to motherhood involves women embarking on a narrative trajectory - anticipating the birth of a baby, becoming and being a mother, motherhood. This period of transition is situated around a given outcome, the birth, and within a range of culturally determined expectations, which operate at both an individual and societal level. In presenting the data to an academic audience I am imposing an order on women's narrative accounts, through a focus on narrative trajectories, which may not have been *lived* in such an ordered and coherent way. I have decided to organise the narratives around linear time, to present the data chronologically and to mirror stages in

transition to motherhood which rely on public (usually medically defined) language. The very act of placing personal accounts in the public (academic) arena requires that the researcher makes decisions about what and how to present womens 'voices', which in turn raises questions about whose 'voice' is being presented¹ (see Chapter 8). The researcher then imposes an order which may not have been lived. As The Personal Narratives Group (1989) have pointed out "the life course itself maybe experienced, however, around other organising principles, from major events to important self discoveries, none of which necessarily corresponds to linear time" (1989:100).

The following three chapters are based around the antenatal period (7-8 months pregnant), the early postnatal period (6-8weeks following the birth) and late postnatal period (8-9 months following the birth). One of the threads which is explored across the chapters is the shifting sense of self within and between accounts. The term 'self' is used in accordance with Polkinghorne's notion of 'self' as "not a static thing, nor a substance, but a configuring of personal events into a historical unity which includes not only what one has been but also anticipations of what one will be" (1988:150). The complexity of the 'self' is noted by Stanley (1993) who helpfully observes that "'self' does not exist in isolation from interrelationship with other selves and other lives and is grounded in the material reality of everyday life: and a key part

¹The term 'voice' is increasingly being used in the social sciences. It is often used to refer to the person providing an account. My understanding and use of the term 'voice' is one shared and described by Natasha Mauthner and Andrea Doucet (in *Feminist Dilemmas in Qualitative Research*, 1998), who make the following comments, "we have come ...to believe that when we analyse interview transcripts we hear stories/accounts/narratives spoken by a person in a voice/voices. With regard to the story, it occurs within a social context and we hear and read the story from within a/nother social context and in a particular research relationship" This process then involves paying "attention to what we think this person is trying to tell us within the context of this relationship, this reaserch setting, and a particular location in the social world, rather than making grand statements about just who this person or 'voice' is" (1998:136-137). See also Jane Ribbens 'Hearing my feeling voice' in the same edited collection. Ribbens writes of her experiences of trying to listen to her mothering voice amongst the multitude of voices which occur around mothering and the difficulty of doing this.

of the constitution of this material reality is formed by the narrations of selves and others that figure so importantly in everyday talk as well as being a 'hidden' component of much academic writing" (1993:206). Narratives then can be constructed and used strategically to present a particular version of a self, for example as a 'good' mother or a 'coping' mother. The longitudinal nature of this study enables and indeed invites reflexivity and a shifting sense of self to be explored within the context of becoming a mother for the first time. The layers within narratives can provide markers to the ways in which women negotiate between the lived experience of mothering and the institution of motherhood (Rich, 1977). Finally then, the aim is not to uncover 'truths' about transition to motherhood, but rather to listen to and explore the ways in which women gradually make sense of, and narrate, their experiences of this period of personal transition. As Plummer notes in the epilogue to 'Telling Sexual Stories', "I have slowly come to believe that no stories are true for all time and space: we invent our stories with a passion, they are momentarily true, we may cling to them, they may become our lives and then we may move on. Clinging to the story, changing the story, reworking it, denying it. But somewhere behind all this story telling there are real active, embodied, impassioned lives" (1995:170). It is glimpses of these 'impassioned lives' I hope to explore.

Chapter Four

Narrative trajectories: the antenatal period.

The seventeen women who were expecting their first child and became participants in this study were all interviewed at between seven and eight months pregnant. At this time their pregnancies were well established and they had all either taken maternity leave at the time of the interview, or were about to. The majority of the participants anticipated returning to work (for further details see Appendix 7) following varying amounts of maternity leave. The interviews were mostly carried out in the participants homes. In four cases another convenient location was used. All the interviews were tape recorded and transcribed verbatim. Analysis of the transcripts revealed that whilst experiences and expectations of the antenatal period were diverse, common themes were discernible in the data.

The focus of this chapter then is to explore how narratives of anticipation are constructed in the antenatal period and the function they can be seen to serve (e.g. being perceived to be preparing 'appropriately' for motherhood). This approach involves engaging with the substantive data within the framework of exploring how and why narratives are constructed and presented in particular ways, how women make sense of this period of transition. The complexities of narrating experiences of periods of personal transition will also be explored through a focus on the different layers of narrative which can be discerned within and between accounts. The degree of engagement and/or resistance discernible in accounts will be discussed throughout the chapter. Substantive areas which have emerged from the data will be used to illustrate how narratives anticipating motherhood are constructed in relation to individuals' perceptions of 'expert knowledge' and their changing

perceptions of their selves. The two following chapters will show how these perceptions can be seen to shift over time. The participants attempts to make sense of this period of transition are most clearly demonstrated in the following areas which will form the focus of this chapter: preparation and engagement with 'experts', the shifting sense of 'selves' and anticipating motherhood. Whilst these areas will be largely explored separately it is important to note that they are also interlinked and interwoven. The concept of 'control' has emerged as a central thread running across all three areas and is used by participants' in different ways to show how they, and their lives, are moving through and experiencing transition to motherhood.

Preparation and Engagement with 'Experts':

The antenatal period is publicly acknowledged in relation to medically defined stages which pregnant women pass through. The medicalisation of childbearing has led to routinised and regulated antenatal care being implemented under the auspices of the National Health Service (NHS) and being available to all². There is also an expectation that all women expecting a child will take-up and use services 'appropriately' (Miller, 1995). Aspects then of the care of the childbearing woman take place within the public sphere of the health care system, and involves interaction with health care professionals³. Indeed, although most of the women in this study used home test kits to establish whether they were pregnant, all participants presented themselves to their General Practitioners (GP's) to actually confirm their

²The extensive literature on access to services under the National Health Service (NHS) continues to show the persistence of inequalities as outlined in Tudor Harts seminal paper, the 'Inverse Care Law' (1971). Recent midwifery literature (Kroll, 1996) has invoked Tudor Harts thesis to describe the inequalities which continue to exist in terms of maternity services and how some groups are particularly disadvantaged. (see also Ann Phoenix 'Black Women and the Maternity Services' in Garcia et al (1990) *The Politics of Maternity Care*. Oxford: Clarendon Press).

³ The term 'health care professional' is used to refer to those practitioners involved in the formal sector of maternity service delivery. This includes General Practitioners (GP's), Consultants, Obstetricians, Midwives and Health Visitors.

pregnancy. Also many spoke of the, now routine, ultrasound scan providing absolute certainty of their pregnancy, giving reassurance that everything was 'safe',

"that was really reassuring because up till then I hadn't really sort of believed in it you know" (Peggy).

"I suppose I didn't actually feel that pregnant until you actually see that baby on the scan, then yes, it becomes more real" (Linda).

"after the scans when that was all sort of safe" (Peggy).

Engagement with health service procedures and different health professionals was openly entered into at an early stage by all participants and regarded as the appropriate thing to do when expecting a child. Similarly, all participants thought the hospital was the appropriate ('natural') place to give birth. In the following extract, Felicity talks about her reasons for not contemplating a home birth and recognises the contradictions in the way in which she has so far constructed her narrative of her experiences of pregnancy,

"the one thing about birth that really worries me is the mess. The mess and the smell...and yes, OK, I slag off the medical profession but I'm going to be damned glad that they'll be there if anything goes wrong" (Felicity).

In the following extract, Kathryn emphasises her perception of the hospital as being the safest place to give birth,

"I would just never forgive myself if something went wrong and I could have saved the baby" (Kathryn).

Phillipa also talks of her reasons for thinking that the hospital is the appropriate place to give birth,

"I mean partly because I just don't know what to expect. I think I'd rather have everything on tap at the hospital if necessary because you don't know really what shape...or anything, so I just think I'd rather, especially for a first baby, I'd rather have the care on hand if I need it..I do sort of think I'd rather come back to my house as something that is kind of sorted

out, to some extent quite clean and what have you, rather than where this kind of event takes place...I can't see the benefit of having it at home. I just think I'd rather go away, do it somewhere else and then come back" (Philippa).

These extracts resonate with those of others in the study and show engagement with, rather than resistance to, a potentially medicalised birth. The women acknowledge that they perceive 'medical professionals' as being the experts and that hospitals have "everything on tap" should it be necessary. The uncertainty of what giving birth will involve is clear and it is this uncertainty which leads the women to engage with those perceived to be experts, to construct narratives which fit with medically defined ways of preparing⁴. Perceptions of what birth might involve interestingly include references to 'mess' and 'smell' which can be contained in the hospital in contrast to the house which can be 'clean' and 'sorted out', a place to return to. Giving birth then is seen as a distinct event, which should occur where both experts (the medical profession) and expert equipment is located: the hospital. More interaction with the medical profession was also seen by some as better, Abigail describes her shared care between a consultant and midwife and comments,

"which is great, it means I'm getting better care" (Abigail).

Stories of engagement with the 'medical profession', either through contact with G.P.'s or midwives, or health visitors at 'Parentcraft' classes, provided a central part of the plot in the women's anticipatory narratives. Whilst becoming a mother was the central, if ambivalent focus (for a few women getting back to work and to 'normal' was the overarching focus), experiences were largely narrated in terms of the participants' interactions with the medical profession. Antenatal preparation then was all about engaging with - or, in some cases, handing over to - others who were perceived to be 'experts'

⁴ It is acknowledged that perceptions of 'appropriate' ways of preparing shifts overtime as medical and health professional practices change.

and who were located within the medical profession. Whilst the women all referred to gathering information about the antenatal period from other sources e.g. books, friends and relatives, these were regarded as less reliable than that provided by health professionals, as the following extract shows,

"I don't like getting information from other people because it's always so subjective and they always want to harp on about their little story, and so I have actually avoided other people...I've steered away from those, those are the most unhelpful, personal experiences that I've steered away from. But I think the books, and the midwives and my doctor, my doctor's been good" (Rebecca).

Information from experts then is ordered as being above 'subjectivity', as a better source of knowledge. Information from parentcraft (preparation) classes was also seen as necessary in helping organise thinking,

"They've been useful in that they've prompted me ...its just made you think or its made you think in order..." (Gillian)

In the following extract Angela talks of her own wishes but within the context of having to seek *confirmation* from the perceived expert, the midwife.

"there's things like...cos I can't make up my mind whether I'm breastfeeding or bottle feeding. So, I'd like to have a go at breastfeeding but you've got to know all the bits and bobs that go with it, like I didn't find out until the other day that, I want to go half and half so that my husband will be involved, and what I was going to do was do half formula and half breast, but I found out that if you've got eczema or asthma in the family, they don't like you doing a mixture, well, I only found that out Monday...so looks like I'm going to do totally breast but I can't confirm that with the midwife until I see her" (Angela).

Similarly, Wendy talks of not getting permission to carry out the feeding practice she had planned, but is apparently happy to be told what to do,

"I'm going for the breast first to see how I get on. I did actually say to the midwife that I wanted to do both, I wanted the bottle and...but she said you can't actually do that...(but) it's been good. They just tell you everything" (Wendy).

The power of the medical profession is also implicit within the extract "*they* don't like you doing a mixture". Wanting those who were perceived to know more, 'experts' to give guidance was expressed by many of the participants, as Peggy remarked,

"don't keep giving me decisions to make, I don't know, I've not done this before" (Peggy).

Gillian also talks in terms of establishing a relationship with the health professionals who will be 'responsible' for her following the birth of her baby,

"it also it gives you a chance to get to know the health visitor ... I mean I know which one will be mine afterwards ... just to sound out a few of their ideas and things and how you ... they're going to handle you afterwards, that type of thing" (Gillian).

Establishing a relationship with members of the health care team was seen as an important part of the antenatal period. Anticipating and preparing to become a mother was not a solitary endeavour but was expected to involve regular interaction with different experts, at different times. Participants produced accounts which showed their particular expectations of the relationship, which were not always met, as Rebecca comments,

"The midwife came round the very first time when I'd just found out I was pregnant and I was very, as I said, confused and very unsettled and she was not that interested. They're very good now, they're very interested and they keep a tab on everything, but at the very beginning, I suppose because people miscarry in the first three months so they don't spend a lot of time with you then in case it's all for no reason. But I did feel very left on my own. They saw me once and then they didn't see me for a month and I didn't know when I was supposed to book up for classes, the ante-natal parent classes, and I didn't know when I was meant to see them and how often and what I was supposed to be doing, and that kind of thing, and I just felt at the beginning I could have done with more support because I really needed it then. Not so much physically, but emotionally" (Rebecca).

The above extract is interesting because it shows how, when initial expectations were not met, the participant is able to make sense of this by focusing on the possibility of miscarriage and this not being perceived to be relevant to the job of a midwife. Having anticipated interaction with the midwife once her pregnancy had been confirmed, Rebecca describes her confusion when this is not forthcoming in the ways she had anticipated, that without them she didn't know "what (she) was supposed to be doing". The different frames of reference being operationalised here are clear in terms of the significance of the pregnancy and when it should be acknowledged as viable by the experts. The uncertainties which surround the process of becoming a mother for the participants in this study, who had all experienced agency within the context of being working women, were discernible to varying degrees in all the accounts collected. Uncertainties led to dependence on what the participants perceived to be expert knowledge. Through engagement with the medical profession and the regular monitoring of their pregnancy, women could be seen to be preparing to become mothers in appropriate and responsible ways. And whilst many of the participants said they did not have expectations of what pregnancy would be like, implicit within their narratives were notions of what pregnant women should and should not do,

"my sister-in-law smoked throughout the pregnancy and I don't think it looks nice as well as I don't think it's good for the baby" (Linda).

"I didn't have any expectations whatsoever...It wasn't really in my scope of thinking...I'm just doing what you're meant to do" (Sarah).

"I don't tend to have expectations actually...I think the side I wasn't expecting and I didn't like that because I like being in control and I didn't like that at all, but the rest of it I suppose was more or less what I thought" (Rebecca)

"I wanted to just carry on as much as I could as normally as possible.... I didn't want it to sort of take over or anything" (Diana).

"I didn't want to waddle...and I didn't want to go on about it the whole time" (Gillian).

And whilst the women's accounts did contain implicit references to expectations of pregnancy, their 'non expert' stance in relation to other experts was apparent in all the accounts. As Philippa comments,

"I did feel very confused to start with because I think they assumed ... There was also, there was kind of confusion over just very silly things like, I remember where you had to sort of take your notes with you and they kind of assumed things like you knew you had to take a urine sample with you and stuff and there was a bit of kind of ... and I didn't on the first occasion and they said, oh I can tell it's your first baby, and I thought no-one ever told me. I don't know, there were just little things like that that I just found irritating, this kind of assumption that it was ... you were kind of stepping in to something and you'd automatically know where to go and who to see, and what sort of ... And I got a note from (hospital) saying come for your booking in, and I thought, what's a booking in? And I had no idea. So there was, I think that was, there was a lack of kind of explanation of the process that I'd be going through in terms of the healthcare I'd be receiving, but once I kind of got my head round it and asked questions, that was fine. And actually the healthcare itself was not the problem, it was more kind of procedural. (Philippa).

Interestingly, whilst Philippa challenges the assumptions that are made about her level of knowledge as a pregnant woman, and what is perceived to be expert terminology "booking in", she concludes that it was not the healthcare itself, but the procedures. Philippa is also tentative in her criticisms "so there was, *I think* that was, there was a lack of *kind of* explanation of the process". The differing perspectives on what pregnant women know, or are expected to know, are interwoven with assumptions around women's abilities to 'naturally' mother. And although this is more apparent during the early postnatal period (see Chapter 5) such assumptions clearly underpin aspects of antenatal care, which paradoxically occur within a *medicalised* context. The messages then can be seen to be contradictory and the women's narratives can be seen as tentatively constructed, drawing on both assumptions of women's abilities to 'naturally' be mothers and the need for expert medical help. The women in the study then considered the procedures involved in their antenatal care as ultimately reassuring, even if they found the ways in which information was given, or the availability of tests, to be at times inadequate. They wanted their pregnancies to be 'monitored' by the

experts, they wanted more information not less, and whilst aspects of monitoring could involve some anxiety, ultimately engagement was perceived as reassuring as illustrated by Clare,

"I think it's been quite adequate. I mean, I had quite an easy pregnancy and there's never been any ... well there was one ... I had to have another scan because they thought the baby might be a bit small, which ...worried for a week until I had the scan and it was perfectly normal... because it's been so normal I think I've never had to really ask many questions. They've always done all the checks all the time so I'm quite confident that everything's been monitored". (Clare).

The 'expert' and reassuring nature of the relationship is summed up by Sarah,

"..goes to the hospital and the woman there was brilliant, she was really nice. And there was a midwife there and a ..some guy who deals with genes, and a trainee doctor who just nodded a lot, and somebody else, some other kind of expert...as well as the ultrasound person and ...and they were brilliant. The fact is that all of those women and men, they know exactly what they're doing, it's their job..." (Sarah).

Whilst all the women narrated accounts of having engaged with experts and sought expert knowledge, and planned to give birth in hospital, some narratives were more complex than others, challenging - whilst engaging - with the medical profession. Felicity challenges the expectations she perceives to surround her pregnancy,

"it's almost as if you have to play along with this game, you have to be really pleased in order to be a proper mum" (Felicity).

Later she talks about the midwife giving her a book on pregnancy which contained pictures of the birth,

"which just made me burst into tears, I don't want to do it" (Felicity).

Felicity feels that the medical profession does not provide accurate information,

"I'd be much happier if they actually said you know well I expect its going to hurt like hell, how long its going to take, sort of maximum and minimum, what they're going to do, but they haven't" (Felicity).

Yet although she constructs a narrative with elements of resistance, Felicity does not challenge the medicalisation of childbearing but rather finds that *she* must be responsible for privately purchasing further tests for Downs Syndrome, which she thinks are necessary,

"The NHS has been awful in terms of...we actually went to see a genetic counsellor to allay any fears (of Downs Syndrome) and she the counsellor was very patronising, 'don't worry dear, go away and enjoy your pregnancy'". (Felicity).

Diana also talks of her needs not being met in the way she thinks they should have been,

"You really need to make informed choices and not many people in the medical profession I've found tell you very much about it...in fact I found my GP to be less than forward with any information, they just don't want to tell you anything" (Diana).

Clearly Diana's perception is that the medical profession possesses a body of (expert) knowledge which she feels it has not been willing to divulge.

Anticipating the Birth.

The 'seduction' of formal, medicalised preparation is discernible in the narratives constructed by participants around the anticipation of the actual birth. This 'seduction' is rooted in notions of risk and safety. Participants can be seen to struggle to produce narratives which can reconcile their perceptions of what 'good', 'perfect' mothers do (eg achieve a safe birth without pain relief) and what their own experiences might entail ('guilt'). The contrasting threads of resistance and engagement were apparent in many accounts, interwoven with contradictory implications of it being a 'natural' process and therefore one that a body can bear, or has been designed to bear. The words 'natural', 'naturally' and 'instincts' were used within the context of anticipating (hoping for) a 'good' (easy) birth and acceptance of what the medical profession may be able to offer. Hopes then were carefully and tentatively voiced in these anticipatory narratives. (NB see following Chapter

for early postnatal accounts of how in spite of what they were narrating here, many participants had thought they would be able to cope with the birth - in ways they don't voice at this time). All the women were aware of the various forms of pain relief that were available, and most operated with a hierarchy of their perceived 'acceptability'. In the following extract Gillian anticipates the actual birth of her child, the complexities of constructing an acceptable (publicly recognisable) narrative around an experience which is unknown and uncertain, yet inevitable, and around which 'public' expectations exist, is clear,

"And also you don't want to be induced either, I'm sure there's a strong feeling that one, you want to do it yourself naturally and second you have a higher incidence of forceps ... and pethidine...Talking with a very open mind on the matter, yes my instincts say that your body will look after itself ... it might need a little help and that's all. Ehm ... but at the same time if things go wrong I'm quite happy ... I'm going to hospital (name), if things go wrong then ... have an epidural, do this, do that ... then I will. I don't think, 'no, I don't want an epidural' ... in my mind I think 'no, I shall manage'. I might try this TENS thing, and I'm quite happy to have some gas and air, so I feel in control. I don't like the feeling of being out of control, ehm and I'm not happy about having pethidine, I think I'd rather have Tens, or gas and air or if things go badly wrong then I'll have an epidural. ... pethidine, I think that with a lot of people it makes them out of control and I don't like that feeling....I think it's the lack of control for me, I think I might be physically and mentally so well under that I wouldn't be on the planet, whereas with gas and air you can just stop it if you feel you're getting out of control and with epidural although physically you lose a lot of control, mentally you still keep it, in fact probably better because you are not distracted by the pain ... But I don't want to be so pushed over having a natural birth that I shall be terribly disappointed if something goes wrong and I need help. I want to try and keep it very open. (Gillian).

The themes of keeping an 'open mind' within the context of believing that 'your body will look after itself' are interwoven with the acknowledgement that this participant might 'need help' and doesn't want to feel 'terribly disappointed' if she does. The complex interweaving of contrasting hopes and anticipated outcomes are discernible in the following extracts,

"if it's excruciating and it's awful, then I decide that I'm going to have an epidural, then I shouldn't feel guilty about it" (Felicity)

"I thought right at the beginning when I thought I was having one (twin pregnancy since confirmed) I didn't...I wanted to try for natural labour...well, I would like (a) go, see if I can do it. But then obviously I'm...I'm not ...I'm not a fool. I know that if I did get in pain then I'd rather have anything that will help me. I'm not sort of this person who wants to be perfect and do it all properly" (Sheila).

"Yes, it scares me, it does, it does scare me. I'm not too worried about the pain...I think I can handle the pain, but as I said its, you know, the thought of the body coming out of that little hole. I wasn't quite sure what to go for as they've got so many different things you can take...I was going to have pethidine, 'cos I thought I don't really want a lot of pain if I can help it, but then at the last antenatal class they said the (hospital name) don't sort of push that, so now I am going for gas and air...so, but it all depends how it goes really it might be a piece of cake" (Angela).

"I'd rather have that (TENS machine) than an epidural, unless I have to, I don't really want to have that ..Pethidine is it?....I don't want to have any painkillers unless I really have to. But probably when I get there it will be completely different...I'm not going to put myself through hell just to stick to my guns" (Faye).

"I mean my whole instinct is to crawl away and to have it on my own...I mean obviously ...I would absolutely love to be one of these people that just floats through and gets by with a few puffs of gas and air..And I'd..I'd like that but I'm not going to say that's what I'm going to do because then I'd be really disappointed If I need something else....I don't like the idea of an epidural at all but then I don't know...I might think its the best thing ever when I come to it" (Peggy).

"if you are tense and nervous and not particularly positive you can create you know problems of anxiety...I don't condemn anybody (but) I think that our bodies were geared and made in a certain way that we can give birth naturally" (Interesting because Participant had a Caesarian) (Helen)

"Well until recently my view has always been I'm not going to suffer unnecessarily. I'll take whatever medical intervention I need to get through it because I don't have any unrealistic views about my pain threshold. You now, I think if I need help I'd rather take the help than be really stressed and upset, I'd rather try to enjoy it a bit, or as much as you can enjoy the experience. But...I am going to keep an open mind" (Diana).

"...and I don't really want any of their drugs. I don't want to have an epidural or any of that...I don't mind anything else, but I don't want that, and I mean, hey, nature you know" (Sarah).

"I just assume that I'll go to the (hospital) and let them do it" (Wendy).

The participants then can be seen to construct narratives by drawing on their own hopes and fears and within the context that women can 'naturally' give birth, without medical intervention. Acknowledging that some 'help' may be necessary is couched in terms of trying to retain some 'control', and trying to 'enjoy' the experience. Yet these hopes are tentatively voiced. Implicit within the extracts is an awareness that even how women achieve birth has implications for perceptions of the type of mother they will be, a 'good', 'perfect' mother, who gives birth 'properly', or a 'guilty' mother who needs medical intervention. It is interesting that whilst a 'natural' birth (without

drugs) is seen as the best type of birth, that engaging with some form of pain relief is, at the same time, seen as offering a means of retaining 'control' over the birth. The hospital then, as a place in which births are managed, is perceived to offer both the possibility of a 'natural' birth and at the same time the possibility of a medically assisted birth enabling women to retain 'control'. Loss of control for these women, who have experienced dimensions of agency in relation to the world of work, was a particular concern. Pain relief then becomes potentially liberating, offering a means of retaining control. Whatever type of birth experience is envisaged or 'planned' all the women regarded the hospital as the appropriate place in which to give birth because experts would be available and expert equipment would be 'on tap'. And whilst the extracts above suggest that women anticipated that control and autonomy could be retained within the context of 'keeping an open mind', the medical profession were still perceived to be the experts, with 'rules' which might have to be followed, as Lillian says,

"Yes, when I've found out that ... if they're happy about people changing positions and things like that, because somebody was saying to me that sometimes they get you into a position that they want you to be in rather than you want to be in and you know, like, so I want to find out ... rules" (Lillian).

Similarly Gillian comments,

"You're going to be stuck with the medical way of doing things, but then I'm happy to go along with that. I don't know what to do if I have problems, I want them to tell me what to do, and its only if everything goes smoothly and you don't have any problems that you should be perhaps allowed to do what you want to do" (Gillian).

The perception of those with expert knowledge being in a position to take control 'I want them to tell me what to do' and also being in a position to give permission, to allow women to give birth in the way they want, reinforces notions of expert knowledge and associated power. Yet the participants did not resist such notions but engaged with them. Indeed the ways in which the participants operated with a hierarchy of forms of pain relief and saw potential take-up as a means of giving them control, could be seen to show

the participants to be sophisticated consumers rather than passive victims. Yet engagement does take place within a medical context - an illness setting - and powerful moral sanctions exist for those who are not seen to conform, to be preparing appropriately to become a mother, or putting the life of their unborn child 'at risk'. The participants' agency then must be considered within the context of a powerful, medical profession (including midwives and health visitors), and widely held, 'public' perceptions of appropriate ways of becoming and being a mother.

The anticipatory narratives constructed when the women were interviewed antenatally were both complex and apparently unproblematic. Women presented accounts in which they spoke of their appropriate actions around preparation, attending antenatal clinics, going to parentcraft classes, having ultrasound scans, changing their diets and socialising habits etc. Having claimed not to have had expectations of what being pregnant would be like, participants produced narratives which were contingent on shared assumptions and stereotypes of what pregnancy entailed. When less enjoyable aspects of their pregnancy were described participants quickly reverted to publicly acceptable language to present what they perceived as more acceptable ways of talking about pregnancy, for example,

"But I know that there's going to be a bundle of joy at the end of the day and that's what I'm looking for..." (Linda).

To talk negatively about the pregnancy appeared to be perceived as not preparing appropriately, not being a 'good' mother-to-be. In the following extract Rebecca talks about not passing her 'apprehensive' feelings about the pregnancy on to her unborn baby,

"but I've never ever throughout the whole pregnancy, and I hope I don't, thought, oh this is a mistake and I don't like the baby, or anything like that. I've always kept positive and talking to him or her and that kind of thing, because even in the womb, well I think they can tell if you go off them and feel vindictive towards them in any way, well not vindictive - it's too strong a word, but ... and I don't want to ever do that...(Rebecca).

Yet, showing the complexities and contradictions within narratives, Rebecca had earlier commented,

" so I was just in the middle of changing my mind when I fell pregnant, so I did have mixed emotions actually. To start with it was quite difficult, and also the hormones bit I think made a difference, it does doesn't it? And so I think I was probably quite grumpy and tearful and a bit moody as well as all these other very real worries and that kind of thing. So I was excited but had reservations as well...in fact that was the good thing because when I first started telling people everybody was so pleased, so pleased, that it made me pleased. That was actually **the turning point** for me because up until then I'd been not exactly negative but very, very apprehensive, I mean really apprehensive. And it was when I started telling people that I actually felt better about it, because everybody thought, I don't know, I suppose they thought I would be a good mother or something, because I do take it very seriously, and I was quite pleased that they obviously have confidence in me" (Rebecca).

A Shifting Sense of Self:

Interwoven with accounts of engagement with the medical profession and, discernible within all the narratives collected, were both implicit and explicit references to the women's shifting sense of their selves. Transition to motherhood was experienced not only as physical change but also as involving changing perceptions, experienced both in terms of how they saw their selves and how others responded to them. Experiences then are contingent on those around us and interpreted in relation to the context in which change is occurring. Factors such as whether a pregnancy was planned, whether a partner is supportive, whether a woman feels positive about her changing physical shape all contribute to the overall experience, and how and whether experiences are voiced. Experiences which are perceived as negative may only be tentatively voiced, for even in the antenatal period the risk of appearing too negative may be construed as not preparing to become a 'good' mother. Transition to motherhood then is regulated and monitored within the public sphere - through interaction with the medical profession - but experienced as a very private and personal transition. In the following extract Felicity describes the struggle that this has presented for her,

"it's very difficult to sort them out into one coherent sentence..it's an experience that I'm glad I've had, but its an experience that I don't want to repeat ...yes, it's been very ... very bizarre. It's been a complete learning curve as my husband says. All sorts of things that I didn't expect to happen are happening. To me, I don't feel any different. OK, yes I've got this ... but I'm still me. You know, OK I will hopefully some time in August have a healthy child, but I'll still be me...so it's like this internal/ external battle, and either having to constantly reinforce your internal feelings to the outside world or just giving up. And sometimes yes, sometimes I just sort of smile and go yes, yes I've been guilty of that"" (Felicity)

The perceived need to retain and still be 'me' for Felicity is clear from the extract, but so to is the difficulty, at times, of achieving this, 'the 'internal/external battle'. The struggle to retain a sense of self, which is experienced as distinct from becoming a mother and should be able to co-exist, is voiced by many of the women. What they acknowledge in their narratives is that others now see them *just* as pregnant women, that this becomes an overriding identity. The implications of not being seen as independent, working women, in control of their lives, indicates the ways in which motherhood is both depicted, anticipated and experienced in our society. In the following extracts the participants anticipate and reflect on their shifting sense of self,

"I've stopped being me, people just see me as a pregnant woman and I don't like that, and I know its going to get worse, people will soon just see me as a mother...I want my life back...I just feel I am not me anymore, I'm just a pregnant woman now, I don't exist anymore in some peoples eyes. I just carry a baby. I don't like that...I don't like not being me ...I am not me at the moment ...And you focus so heavily on 'week 40' your whole bloody life disappears..." (Abigail).

"I know I'm not going to be me anymore...I'm not going to be an individual anymore...my life's totally changed the minute I found out I was having twins" (Sheila).

"I think it's all bound up with the fact that you ...there's something else going on that you haven't got any control over, that you are not the person that you were anymore, and you know from now on you're going to be a mother which is another role" (Felicity).

"you become a non-entity, almost overnight, so that by the time you have the baby, you're just a mother" (Diana).

"I think you have to fight more to keep your individuality...You know you have to fight to be the person that you, rather than everybodys preconception of what a mother ought to be, or what a pregnant woman ought to be, or what you ought to be doing" (Peggy).

"At one point, I don't know if this is because I was feeling emotional, I feel as though like me and myself is sort of like taking a backstage at the minute. I find that really sort of ... I

find that hard, you know sort of like, you know, Mmmm, and that's quite ... that's not very nice... you know you lose a little bit of your identity" (Lillian).

"Oh god, it's the end of my life as I know it, and I still feel that on bad days" (Philippa).

Struggles over "the fragmentations and coherences of self" (Stanley, 1993:207) are discernible in the above extracts. The women construct their narratives in different ways and in relation to their particular experiences of agency. Indeed the need to 'fight' to retain a sense of individuality reinforces the struggle that is involved in maintaining a sense of their selves. The analogy of the 'me and myself' having taken 'a backstage' in Lillian's narrative is very powerful and resonates with many of the other women's experiences of transition to motherhood. Yet Lillian's narrative also encapsulates the contradictions experienced in the transition to motherhood, especially in relation to the perceptions of others,

" I mean, I don't know if it's me that's imagining it, but like my father looks at me differently. He can't look at me as if it's a little girl any more, I'm a mother, I'm going to be a mother. And he's ... so that's quite a nice ... that's a positive aspect of him looking at me as an adult. And then some people look at you saying, you're a mother now, you haven't got like your own sort of intelligence I suppose really" (Lillian).

For some participants transition to motherhood was presented as unproblematic and in positive term,

"I don't know, because I have been well and everything, it's not really changed me and obviously my size, but it's not been too much of a problem....(feels) happy with myself sort of thing" (Faye).

"Seeing me as a potential mother rather than a professional teacher - my image has changed. To start with I rebelled against that but now I'm kind of quite looking forward to it and happy with it" (Rebecca).

"Have to put up with a lot though. Back pain. But it's worth it in the end, hopefully" (Wendy)

Talking about her experiences of pregnancy and the pregnancy diary in which she has noted down her changing feelings during pregnancy, Helen comments that it's,

"...better than I'd imagined it to be...I mean I love the look of pregnant women, I think they look absolutely gorgeous...I have stayed very trim, I desperately wanted to get big and fat" (Helen).

The potential struggles involved in making sense of a changing sense of self, through experiences of transition to motherhood, are also discernible around perceptions of 'control'. The theme of control, or loss of control, emerged in relation to the participants' struggles to maintain a sense of their self(s). Struggles around attempts to maintain a sense of self ('me') and the recognition of the difficulties in achieving this, were often linked to a changing body shape. In the following extracts some of the participants talk of their experiences of the changes,

"I don't like losing my body, not the shape of it, but just feeling...the having something inside it, and not having control over it is odd to say the least" (Abigail).

"I feel that from being the person in charge work - wise, to the person that is being taken over by something else, or someone else is quite a lot to take in...It's as if your whole identity changes from here on" (Linda).

"Yes, I didn't like the idea of getting fatter. It's fine now because it's obvious that I'm pregnant, but at the beginning I had real traumas because people didn't know I was pregnant I take pride in my appearance and that was hard.... I mean, my perception of my body image and the clothes I wear which make a statement, because I think the clothes you wear do make a statement, don't you, so having to wear these peculiar floaty dresses which isn't really me" (Rebecca).

And whilst the above extracts reflect shared concerns with changing shape and the implications of this for the women's sense of their self, the complexities and contradictions in narrating personal experiences of change are apparent in extracts from Helen's account. Helen talks about her changing shape at an early stage of the interview,

"I've had a very sort of positive reaction to you know my body and how I've been growing and everything....."

Helen later comments,

"I have to say it's been one of the most uncomfortable physical states that I've ever been in and it's so difficult to describe to anyone...I feel like my body has been taken over by something else...it's a bit like being an alien...people touch you, touch your stomach, stare at you ...you just feel that you're sort of not human" (Helen).

And towards the end of the interview she concludes,

"as far as I am concerned it's such an amazing thing of you know nature taking control and you know producing this little ...being"

Whilst these extracts can be seen to show the complexities and inconsistencies in producing personal accounts of transition, they also raise questions about the ways in which narratives may be produced for particular audiences. It is possible here that Helen conforms to what she perceives as appropriate ways of talking about pregnancy in the first extract, becomes more comfortable with me as the researcher as the interview progresses and talks in what could be perceived as less acceptable ways of talking about pregnancy - 'being an alien' and 'not human' - before reverting, as the interview comes towards its close, to more publicly recognisable ways of talking about pregnancy, 'producing this little...being'.

Anticipating motherhood in relation to a return to work, and therefore for some of the women, a return to 'normal', was a common theme running through many of the accounts. A return to work was seen as marking the end of this period of transition. Work could be seen to represent certainty in the women's lives in stark contrast to the uncertainty which surrounded their present journeys into motherhood. At work they were in control, they were the 'experts' and a return to work was seen as a way of retaining/ regaining a sense of another self.

"You can see these people who are so focused on child...there's nothing wrong with that but its not me. I've struggled losing my identity as it is and I can't go...I can't go forever just being someone else, I've got to be me again" (Abigail)

"I am one of these people that their self identity is locked into what they do...in terms of my own self , I would like to do something" (Felicity).

"yes, yes, yes, for me it is a good idea" (Lillian).

"I'll come back to work in June, for 2 days a week, I couldn't work full time... so that will get me out" (Angela)

"I mean in an ideal world I wouldn't go back to work, I mean I've always ... before I got married I always said that I felt that a mother should stay at home but I think as you ... I mean this is another sort of an ideal ... an ideal that's changed over the years. I mean, I love my job and I really enjoy the stimulation and I think ideally I would go back to work part-time if that were possible - and they've said it is but ... I've said that I'll go back full-time and do my best and if that doesn't work then..." (Kathryn)

"I've sort of started thinking about childcare as well when I go back to work...(Partner) thinks I'll be bored..not bored, but bored with being stuck at home.."(Clare).

"I will do definitely (return to work), but only part-time, because I think you should put in ... I mean, what's the point in having the baby unless you're going to look after it...(but) yes, definitely, otherwise you might go insane" (Sarah).

"I didn't particularly want my children to go to a childminders or a creche or something...doing it this way (temping on a p/t basis) hopefully we'll be able to do it between ourselves and I'll still have my identity as well" (Sheila).

Others are undecided or see full-time mothering as their new job,

"because we decided we would either have children or I would apply for deputy headships and headships and that would have been a big change because I would have been in a very, much more important job and being looked up to as a more important person, and I decided not to go for that. I decided to go for motherhood which also I think if you do it properly you're respected and looked up to and trusted more I think in a way. Because you're not the young, frivolous person that I was before anyway, but because you're a mother, you have to be a responsible person, or should be"(Rebecca).

"It really depends how bored I get..I've kept my job open so I can go back...I keep saying if its awful I'm going to get a full time nanny and go straight back to work" (Peggy).

"I may actually adore it and think I'd love to be a full-time mother and I'll find that completely satisfying, but at the moment I can't really imagine myself feeling like that" (Philippa).

Notions of what life with a baby will be like are clear from these extracts.

The implications for those anticipating returning to work are that being a mother who does not work outside the home will not be 'stimulating', that they might be 'bored'. A return to the public world of work is seen as offering the possibility of women regaining their 'identity' and being 'me again'. Others attempt to reconcile their ideas of what 'good' mothers should do 'stay at home' with their perception of their own needs 'you might go insane', whilst others construct motherhood in terms of a job to be done 'properly'.

Anticipating being a Mother/ Motherhood.

Whilst all the narratives discussed in this chapter are constructed in the context of anticipating having a baby and becoming a mother, in this section specific extracts relating to becoming a mother will be explored. The ability to 'cope' is linked to the process being 'natural', which implies that women should be able to cope, yet women's accounts remain tentative, words such as 'worried' and 'frightened' are interwoven into the narratives,

"...and she (a friend) was ever so worried about not being able to cope..but I think once it comes it all goes...it is natural...uhm, I was ...frightened..will I be able to cope?" (Angela)

"It all seemed so easy nine months ago...as if it was something that would just come naturally and now that I'm very aware it might not and I'm a bit worried that I won't cope" (Diana)

"but I think maybe when the baby comes I'll ...it will be very natural to me...I would say that my personal views on motherhood are you know very positive and yes, uplifting" (Helen)

"But being a mother...yes, I mean obviously I do have lots of trepidation, 'will I be alright?'" (Gillian).

"I'm mainly excited and a bit anxious about if I'll be good and if I'll be able to with everything" (Clare)

"I do feel quite ... I do feel quite frightened about the future in some ways, especially the first few weeks. I think how am I going to ... it's not how am I going to cope, but it's almost as if I'm not really looking forward to it" (Philippa)

"...and I think how on earth am I going to get everything done. Yes, I mean that does worry me, because as I said before, because I like things so well ordered. You can't control a baby, you can't say, stop crying now" (Kathryn).

"Terrified...the responsibility, doing things right, just looking after a whole human being...but then again it's ...well everybody else can do it and I'd rather just do it by instinct" (Sheila).

"lots of changes...I think we both worry about...well, not worry but its going to be very different having a baby there ...you know we've been together for nearly 10 years, just us, and then there's going to be a little person as well" (Faye).

"There's this idea that as a mother you will love your child, and as a child you will love your mother and that's not necessarily the case...It would just be nice if we get on and we both survived I think" (Felicity).

Underpinning these extracts are assumptions that there are 'right' and 'good' ways to mother. Concerns about the ability to 'cope' are voiced tentatively

within the context of mothering being dependent on 'instincts' and being 'natural'. Anticipating mothering involves both uncertainty, and at the same time anticipatory narratives are constructed within the context of potent ideologies that mothering is 'natural'. The participants concerns then about not being able to cope suggests that failure to get it 'right' will have implications for both their sense of self and the ways in which they are perceived by others.

Concluding Discussion.

The women in the study can be seen to carefully and tentatively construct anticipatory narratives of their experiences of transition to motherhood. The journey into motherhood takes place within the context of powerful ideologies which exist around mothering. Its positioning at the interface between the social and the biological has critical implications for the ways in which women anticipate and experience their own transition. Participants can be seen to carefully negotiate their journeys into motherhood, through public expectations and assumptions and private experiences and these may not always coincide. The resulting narratives reflect both the wish to be seen to be preparing appropriately to become a mother, and uncertainty that a period of personal transition can bring.

During the antenatal phase expert knowledge is sought. Women willingly engage with those they perceive to be the experts in relation to childbearing - the medical profession. The increasing dependence on experts and expert knowledge has been noted in late modern society (Giddens, 1991; Fox, 1993). Regular engagement with the medical profession and their expert equipment can be seen to engender feelings of safety, the regular monitoring of a pregnancy is perceived as a way of avoiding unnecessary 'risk', as ultimately reassuring. As Reissman (1983) has argued, "women have not

simply been passive victims of medical technology (but) rather they have actively collaborated in the medicalisation process in order to satisfy their own needs and motives" (cited in Rajan, 1996). Lupton (1994) too has argued that medical technology may actually be a 'liberating' force in women's lives. The hospital then is seen as the appropriate and 'natural' place to give birth, and the "cultural dependence on professional health care" noted by Oakley (1979) appears complete. The ways in which preparation for motherhood is entered into can be seen to have implications for perceptions of the woman as future mothers. Preparing 'appropriately' was all about being a 'good' mother. The discussions around pain relief at the time of the birth illustrated the potency of such perceptions. 'Good' and 'perfect' mothers did not need any pain relief to assist them in getting through the birth and whilst some women spoke of 'not going through hell' without any form of pain relief, there was an underlying assumption that giving birth was natural and so therefore should be coped with. Yet in contrast to notions of women's 'natural' abilities, engagement with pain relief was also seen to offer the possibility of retaining 'control' during the birth. The women's narratives around anticipating the birth are both complex and at times contradictory. Threads of both public knowledges and private experiences and hopes are interwoven.

The powerful ideologies which surround mothering (and were discussed in Chapter 1) can be seen to both inform and shape the narratives produced by the participants. The context then in which narratives are produced is key, as too is the location in which dimensions of agency are experienced. The participants in this study identified themselves as predominately middle class and this clearly has implications for their experiences of agency. Bailey (1999) has recently written of motherhood as providing a rich opportunity for 'narrative movement' because of the "new relationships and new

characters" encountered which provide new materials for the construction of a narrative (1999:351). However missing from Bailey's assertions around motherhood is the acknowledgment that narratives collected during the antenatal phase are always anticipatory in their construction/production, the women are *preparing* to become mothers but are not yet mothers. Narratives constructed during this period are then always tentatively produced and cautiously narrated as women negotiate their way through public knowledges and private experiences.

The different layers discernible within narratives collected during this antenatal period can be seen to reflect an awareness of public assumptions "a bundle of joy", and private expectations "I'll take what ever medical intervention I need" and, sometimes, glimpses of personal experiences, "I've got to be me again". In these anticipatory, antenatal narratives the personal is only very occasionally voiced, telling your story during this period is all about presenting a publicly recognisable account of preparing appropriately for motherhood. Yet the lived experience of childbirth and becoming a mother has major implications for the ways in which *postnatal* narratives are negotiated, constructed and presented. In the following chapter the ways in which the participants produce narratives of the early postnatal period will be explored.

Chapter Five

Narrative trajectories: becoming a 'mother'.

Introduction

The early postnatal interviews were planned, during the design phase, to take place at between six and eight weeks postnatally. Whilst some of the interviews were carried out during this time frame, others took place after a slightly longer interlude, the latest being carried out sixteen weeks following the birth. One of the reasons for this unexpectedly protracted phase was the problem of women finding the time (which had not been a problem antenatally) postnatally, to be interviewed. Having a baby had completely changed the pattern of their days. Feeling ready to be interviewed may also have been a factor. The participants were all telephoned to re-establish contact and in order to make arrangements for the next interview. One participant withdrew (temporarily) during this phase of interviews (see Chapter 7). Once again, the interviews were carried out in the participant's homes or at another convenient location. Prior to the interview, I would listen to the tape recording of the antenatal interview and incorporate things they had said into the postnatal interview schedule (see Appendix 5).

The birth of a child can be seen to provide a narrative 'turning point', crucially anticipation becomes experience. The narratives collected during this period are more complex than those collected during the antenatal interviews. Whilst expectations can be narrated with reference to publicly recognisable and acceptable ways of preparing to become a mother, lived experiences may be more difficult to locate and indeed to voice. Many of the women produced their stories within the context of asserting that they were “now feeling better”, “now able to cope” and, “I thought if Tina had come

last week”. Relating experiences of the birth provides both a starting point for the interview, and a 'narrative turning point' (Franks, 1995) in terms of lived experience in contrast to anticipation, providing an ontological shift in the ways in which becoming a mother is/can be narrated. In this Chapter then the birth and the early weeks at home will be explored. As in the previous Chapter, the substantive issues of engagement with perceived expert knowledge, and the shifting sense of self(s) will be explored in relation to how women construct and present narratives around early experiences of being a mother. The function of producing particular types of narrative will also be explored in conjunction with the layers which are discernible within narratives. As identified in the antenatal period, 'control' is a recurrent theme.

The Birth.

In the accounts collected during the antenatal period, the women could be seen to construct, at times, contradictory narratives when anticipating the birth. The interwoven threads of birth being a 'natural' process and one that therefore could be coped with, together with notions of pain relief offering women the ability to retain control through a process which was both 'natural' and uncertain, were clearly discernible. During the early postnatal interviews, the overriding feeling was that the birth had not been as the women had been led to believe it would be. Many felt that the 'experts' had not, on reflection, prepared them adequately. Yet it was not just the perceived experts who had concealed what giving birth might actually be like, as one participant said to me, "to be honest, even you didn't tell me what it would be like" (Felicity). The conspiracy of silence which some now felt had surrounded their preparation was noted by Faye who relates a conversation with her second time pregnant sister-in-law,

"I said to her when Emily ...the day Emily was born I said what the hell are you going through that again for? And she hadn't told me" (Faye).

The perception by the participants, that if they prepared appropriately, their birth would be 'better', or that they would be more able to cope with it, was implicit within the antenatal narratives. The narratives produced in the early postnatal interviews stand in stark contrast,

"So everything I'd planned went completely wrong...The pushing bit was absolutely the worst thing that I have ever experienced in my entire life because it was three or four different sensations to me all at once...I had an epidural which I didn't want beforehand but at that stage I would have done anything because I was convinced I was going to die, literally" (Felicity).

Eventually Felicity has a forceps delivery,

"...awful, it was the most..it's the worst thing that I've ever had to go through. I just felt completely violated ...I just can't believe that for somebody who's usually so healthy and doesn't have any tablets, or anything, that I've had all this medication and medical intervention over what's supposed to be a natural event...I thought I'd give birth naturally, quite easily because everybody said you've got childbearing hips...so it's turned out completely wrong for me" (Felicity).

Similar accounts of expectations and plans being abandoned, and control handed over/taken over by the experts were narrated by other participants,

"So then you see they threatened me with forceps, but once I was threatened with forceps I suppose I pushed harder, and out she popped...but I thought my birth was going to be easy. I don't know why, I just thought that ... I expected a sort of four-hour labour, I didn't really expect stitches or anything like that. I thought ... I just thought my body would be very good at that, and it wasn't...I think I did lose control. On the gas and air, I had quite a lot of gas and air because I was just on it for so long" (Gillian).

"and after about 2 hours I was just in agony and I couldn't stand it anymore...I thought about it (requesting pain relief) at one stage that was when it was nearly all over so I thought well, I've gone this far, I don't really need to bother....but it was pretty horrendous mind you...You can't really explain the pain of it...I mean it's horrendous, but..." (Faye).

"and I said, oh, you know, I've got this twinge ...if this is what it is, then this is fine because this doesn't hurt at all! I can cope with this! But then they started getting stronger and stronger... So I just tried to carry on and have a bath and walk about a bit and that kind of thing, but by about 2 o'clock in the morning, they were really getting quite painful, more so than I thought they would be, because having done yoga and everybody saying how fit and healthy I was, I thought oh well, this is going to be a cinch, it will probably be all right, I'll just keep the breathing up, but it really, really hurt I thought, so I was getting slightly panicky, thinking oh goodness me, I'm not really doing very well... Because people had said if you keep the breathing it's bearable - well it was bearable because I bore it, but...So I was

there thinking, this is so painful, I'm surely going to have to have a caesarian or forceps or something like this, surely it can't be this painful...I think if I'd have just known that I was having a normal delivery but it was painful, I think that's what I would have liked to have known" (Rebecca).

"I wanted to have a water birth originally and because I was induced I couldn't, that's why I was stuck on this bed. And I had like ... I had everything in the end, I had an epidural ... I knew that ... you know ... originally they examined me and they said you're only three centimetres, you can't have an epidural yet, and I was absolutely desperate, ... and they made me hang on for another two hours, and I was like ...I just thought I was going to die"(Clare).

"it got hideously painful, but it wasn't what I was expecting" (Abigail).

"I was admitted and I wanted to ... I didn't want to have the baby in the water bath but I wanted to spend as much time in the water bath as possible. But by midnight I was getting really tired with the gas and air and I just said 'I'm sorry I need an epidural' because by that time I'd been going almost 24 hours...And then the anaesthetist or the doctor who was going to do the epidural took ... he was doing something else and he took an hour and a half, and that was the worst bit waiting for him...It was a long time and I remember being in absolute agony...he was absolutely stuck fast, and after pushing for an hour and ten minutes they called in the doctor and they got ... they turned him with a ventouse and then gave me an episiotomy and forceps delivery. So he was born at 9.03 on the Saturday....I sort of felt in a way that I'd failed by having to go for an epidural but I just knew that I couldn't go on any more....I'd been to all these sort of aqua-natal classes and everybody said that going sort of swimming helped...helped the pregnancy. And I just...I just thought you know, I'm really fit"" (Kathryn).

"I mean I think secretly I sort of thought I'm quite strong, I'm quite resilient, I'm quite fit, I should be able to get through this really. I mean I didn't really ... I don't think I ever really said that to anybody but I think that was kind of how I felt about myself, I sort of thought I'd never ... I thought I dealt with pain - could deal with pain - quite well. But it was just beyond anything that I kind of could deal with really. It was certainly much more agonising than I expected, and even now I can't remember how agonising it was, which is the funny thing, you sort of forget it, and I'm kind of tempted if people say how was your labour I just say oh alright, and I think it wasn't actually at all, and you know I have to say ... if anyone says to me ... you know if you catch me saying it's not that bad, remind me that it is" (Philippa).

"I just want an epidural, I thought this is it, I can't cope with this, this is ridiculous, in fact give me a caesarian, just knock me out...I didn't scream in hospital because I was more sort of ...I felt I had to like try and control myself" (Diana).

At a later stage in the interview, Diana comments,

"and knowing afterwards I thought well you know I wish I'd realised, I would have maybe felt a bit more in control, because as it was I felt completely out of control" (Diana).

The birth then for these and other mothers in the study was not as they had anticipated. The preparation they had engaged in was not perceived, retrospectively, to have been helpful. From the extracts above it is clear that the women had thought their bodies would be able to cope, that they were

'healthy', had 'done yoga' and 'aqua-natal classes', that they did not see themselves as women who would need medical assistance 'I just thought my body would be very good at it', 'somebody who is usually so healthy and doesn't have any tablets'. Giving in to medical intervention, involved mixed feelings for the women, but the most palpable were of gratitude and defeat 'I'm sorry, I need an epidural'. As Felicity comments "it's an odd mixture of being between relief and resentment of the medical profession". The tentative voicing antenatally of choice around different forms of pain relief enabling control to be retained, is not realised during the birth. Most of the women spoke of handing over, at some point during their labour, to the experts as the following extracts show,

"Yes, well because they were worried about her, although she showed no signs of distress at any point, but meconium in the waters means you've got to have what they say which is...the drip...well I don't know if ...much choice. But by that time I was thinking I want her out and whatever you think is best and get on with it" (Gillian).

"And I was desperately trying to breathe in and that, and I just couldn't, lost it totally. And I had the epidural, told the anaesthetist he was god...Because I tried gas and air, revolting, disgusting, let's throw up, it was obscenely revolting. And the TENS machine was well, a total waste of time I think, but it felt as if you were in control, and so I had no pain relief at all basically, other than the epidural when I eventually succumbed.." (Abigail).

"When he (consultant) said to me I think we should do such and such, and I just said yes, whatever, you know best. I just took...gave it totally over to him...I knew that I would just want somebody to take control and take over from me" (Sheila).

Yet even requesting, or accepting, some form of medical intervention did not mean that all aspects of control were perceived to have been lost/handed over. As the earlier extract from Diana shows, she requested a range of forms of pain relief, yet didn't allow herself to scream in hospital because 'I felt I had to like try and control myself', yet the complexities of narratives are clear when she later talks of feeling 'completely out of control'. Aspects of control then are either seen to have been 'lost', 'taken over' or given over and/or retained during births, in contrast to what had been anticipated. Yet reflecting on their antenatal preparation, the participants point to the failure

of experts to prepare them for what birth might really be like, yet acknowledge the difficulties of doing this,

"Yes, I suppose looking back on the ante-natal care, it was as good as I suppose it could be, given the fact that the midwife who was leading it had no idea basically of what we were all going to go through. She knew the kind of experiences that can be gone through" (Rebecca).

"I just think they could do with being a bit more realistic without frightening you you know because I know that they don't want to tell you what it's really like because it can sound quite terrifying if you try to say you know the pain is like indescribable and it is, but you forget, you do forget, I know that it was horrible but I can't really remember how horrible" (Diana).

"everybody was saying that they don't tell you enough about the birth and what its like" (Faye).

Engagement with experts then was perceived as a necessary part of antenatal preparation and continued through the process of labour and giving birth. For two of the participants the period leading up to the birth of their babies became protracted when their 'due dates' were significantly exceeded. A focus on the narratives that these two participants constructed to describe this period can be seen to initially resist expert knowledge/advice, yet eventually succumb. In her antenatal account Helen had spoken of her belief that "our bodies were geared and made in a certain way that we can give birth naturally" and so when her pregnancy reaches 42 weeks it is not a surprise that she resists medical induction.

"And it went on and on and on and basically she was ... she was at 42 weeks and they had booked me in at this time to actually come in and be induced, but I was ... had quite a strong opinion on the fact that I really wanted it to be spontaneous, I felt as though that we'd waited nine months and she was going to come you know when she's ready as long as I wasn't putting her at any sort of risk at all, so I'd spoken to the consultant sort of like at 42 weeks and he said well you've got enough fluid around the baby and the placenta's still healthy, come in on a daily basis...so anyway we went to three week over..."

Although she had been 'booked in' to be induced, she challenges this and proceeds to await a 'spontaneous' start of labour. Helen's resistance is bound up with her strong beliefs and earlier assertions of birth being a 'natural' process, for to resist expert knowledge within the medical arena could be

seen as involving risk. Helen speaks to the consultant and negotiates her way around induction by agreeing to visit the hospital on a daily basis. Philippa can also be seen to resist and indeed challenge the basis of expert knowledge. At almost 43 weeks pregnant she finally gives birth but only after a struggle with the experts. At 42 weeks pregnant Philippa is booked in to have her labour induced, but the attempts to get her labour started don't work,

"So they said come ... well no actually, what happened, the registrar said well we could go to the consultant or whatever and they said have a caesarian this evening, which I was just like why? Tell me why I have to have a caesarian you know ...I mean we sort or tried to work out why. We were just ... the only thing I could think of is that they kind of ... they have ... they booked ... you're booked in to have a baby on that date and if you don't have it ...one means or another! And the registrar seemed to disagree. I mean I said is this normal policy or whatever or is this what you normally do and he said well I've never really come across this before and I've never used this method of induction before, I'm just doing what your consultant says and all this sort of thing, so it was a bit ... I just felt a bit kind of removed from the person making the decision and yes, it was all ... and no-one could tell me why I had to have it, they said well you're fine and the baby's fine and why couldn't we just leave it and that'll be it. And they said well ... well basically they said stay in overnight and see how you feel in the morning, but we would recommend you have a caesarian tomorrow morning. And I was just really unhappy about it. I mean had the baby been in any danger or had I been ill or anything I think I would ... it would have been fine to have a caesarian. I didn't really mind in a way, but I just thought why do I have to have what is fairly major surgery you know, and I knew it would take me longer to recover from it as well. I also wanted you know wanted the opportunity to do it myself naturally" (Philippa).

It is interesting that both participants are driven by their beliefs that birth is a natural process that they and their bodies should be able to achieve without medical intervention. These beliefs are however tempered with acknowledging that elements of risk must also be considered. The apparently arbitrary basis on which expert knowledge was being used to make decisions, was challenged by Philippa, 'no-one could tell me why', the registrar said 'I'm just doing what your consultant says'. The hierarchical nature of expert knowledge is also illustrated in Philippa's account, where the registrar admits that he is deferring to the consultant, and some of the midwives applaud her stance,

"I mean a few of the midwives sort of said good for...you know good for you"

But both women eventually give birth in hospital, Philippa does avoid having a caesarian, unlike Helen. Helen's beliefs in her own ability to give birth 'normally' and 'naturally' are retrospectively rationalised in terms of her mother's and sister's experiences,

"you know I suppose that you always look at your sister and your ... your family and your mother and ... you know never had any problem whatsoever, always had normal ... you know normal labour and normal childbirth, to the point where you know ignorantly I had never ... you know all the books and everything, I think that I was quite well read through the pregnancy, but whenever I got to the part about the caesarian I flicked over it because I thought well it wasn't going to happen to me".

Having resisted medical intervention, Helen talks about finally having a 'medically run labour',

"So at this point I knew that it was going to be a medically run labour, because they'd said you know the only thing that we can really do is ... is start you off on the drip, give you an epidural and take it from there, all the things that I said that I didn't want I ended up having. There was me ready with my aromatherapy oils and TENS machine and ...because I knew that everything was pointing towards a caesarian...they had taken control.... But in fact I don't feel disappointed about it in any way I suppose because it was taken out of my hands. I wasn't allowed to be in control. The time that I was in control I did everything that I possibly could and...so I wasn't allowed to be in control I suppose once they started me on a medically induced labour, it was...it was over to them at that point....I mean they had really taken control sort of from the time that they gave me or administered the first epidural and I knew that it really wasn't down to me at that time, and ...But it was quite an emotional time...because things weren't going to plan" (Helen).

Helen weaves a complex plot voicing her hopes and expectations, 'a natural birth', and her experiences which involved an 'emotional time', but which at the same time she says she doesn't 'feel disappointed about in any way'. The taking over of control is acknowledged, but in the light of Helen having done all she possibly could and then not being 'allowed' to be in control. Yet interestingly Helen, having reflected and produced a narrative of becoming a mother which contains elements of resistance, reverts to a much more publicly recognisable way of talking. In the following extract Helen comments on the birth weight of her baby,

"they weighed her and found out she was 8.11 which is quite nice ...Well, she was 43 weeks so ... I know, be grateful for small mercies I think. Yes, and to be perfectly honest with you it really has been plain sailing since then. That day was very up and down, very emotional,

it was like a ... you know a whole story you know from start to finish, but since then it's all been ... it's been fabulous" (Helen).

The analogy to a 'whole story' implying that it is now finished is interesting, so too is the implication that she got something right by giving birth to a large baby, 'be grateful for small mercies'. Helen can reveal her unanticipated birth story in the context of the assertion that 'it really has been plain sailing since then' and 'since then it's been ...it's been fabulous'. The tensions and layers (the lived experiences) beneath the 'fabulous' time she is claiming to currently be enjoying are only revealed in her final interview and the end of study questionnaire. It is only when her baby is nine months old (at the time of the final interview) that the struggles she is encountering during this interview to produce a 'coherent' and publicly recognisable account of new mothering, can be voiced (see Chapter 6).

Hospital to Home.

The participants spent varying lengths of time in the hospital following the birth, from a matter of hours to a week. From the interview data it becomes clear that for some the focus of interest of the medical profession was perceived to shift swiftly following the birth. The baby, or other expectant mothers on the wards were of most interest to the experts now. As one participant commented,

"(they) don't give a damn...so I think in a way I feel as if they were completely obsessed by me and my body beforehand. Now they don't care. It's almost as if ...you know...now I'm not an incubator, then I've just got to get on with it really" (Felicity).

The women were now mothers as far as the health professionals were concerned and the process of gradual disengagement began. Women were expected to naturally know how to mother. The following lengthy extract illustrates both the enormity of the changes which occur around the time of the birth and the competing perceptions amongst those involved. Wendy is in

hospital to have an elective caesarian. She is expecting twins following successful IVF treatment.

"I had baby blues in hospital...I stayed in there for a week....Well they told me that I could go home on the Friday. I had them on the Monday and they said I could go home on the Friday. But I said, no I'm staying, and they let me stay and said I could stay for a bit longer if I wanted to. They were saying about this mother and baby place I could go to, in Aylesbury or Banbury? Because they said we should have been counselled, because they were IVF babies, but we never had anything. Because you just go in and you think, oh my god, I'm having these two babies tomorrow and they're just there and you think, god, what do I do? You just have to know it all. I don't think they've got much time for you up there because I was trying to breast feed Ben and I used to ring them to help me to fix him on and that, and it used to take them ten minutes to come along. Fifteen minutes and you think, I can't cope with this and I just used to give him a bottle. I had to beg them one night to take them off me for one night and the next night I thought, well I'm not going to ask them again because you just think, do they really want them? It's really bad. They kept saying it was part of post-natal depression, but it wasn't. They sent a psychiatric woman in to see me and she said, do you feel suicidal? and I said no. I was on the seventh floor. I said if I did I'd be jumping out that window by now. We went in on the Sunday and that's all they kept talking about, because I was quite tearful anyway when we went in and she kept saying I've got to tell you about post-natal depression, and I said I haven't got it. I'm just teary because I'm in here and I'm going to give birth in the next 24 hours...I wasn't the only one up there crying. There was quite a few of us. It was weird though, having these two babies just lying there and thinking, god, what do I do". (Wendy).

This extract shows Wendy's perception that she had not been properly prepared "because they said we should have been counselled, because they were IVF babies, but we never had anything", her sense of being unsupported once the babies were born is also clear "well I'm not going to ask them again because you just think, do they really want them?". But Wendy explains that she was not alone in feeling 'teary', "...I wasn't the only one up there crying. There was quite a few of us". The competing perspectives between Wendy and the other professionals is also apparent. Wendy challenges the diagnosis of postnatal depression and the need for a 'psychiatric woman', rather she makes sense of her own feelings within the context of the enormity of what she is going through "and they're just there and you think, god, what do I do?". Felicity also talks of her experiences in hospital following the birth of her baby,

"In the hospital - I mean this is another thing about the isolating experiences - they stuck me in a ward with four beds in it and I was the only one there. So I'd had this horrible experience and then I was stuck in this room on my own and I just felt as if I was the only

person in the entire world and nobody wanted to know me. It was awful. And they kept doing things like forgetting to bring my meals because I was the only one that ... 'oh we didn't know anyone was in there'. So of course there was just floods of tears 'I'm not even worthy of them bringing me a cup of tea' (Felicity).

The shift from hospital to home marks both the beginning of a return to 'normal', and the gradual disengagement of medical and health professionals: childcare and childrearing are a privatised responsibility. Felicity describes trying to convince the hospital staff that she could cope in her bid to be allowed home,

"you know, I have to show them that I'm fit to go home with this child" (Felicity).

The different localities can be seen to represent different 'public' and 'private' spheres, the hospital one in which experts are seen to largely take control and the home being where mothering 'naturally' occurs and the privatised responsibility for childcare is undertaken. Yet being at home with a new baby was not experienced as 'natural' by many of the participants. The sense of not knowing what to do was profound. Indeed Philippa describing the early days at home with her new baby says,

"I just wanted to go back to hospital actually the whole time...after being home for a couple of days, I thought I just wanted to go back, I want someone else to be in control" (Philippa).

During the early postnatal period, midwives continue to be responsible for mothers until ten days after the birth at which point the health visitor takes over. The early postnatal phase is characterised by interaction with the various health professionals largely taking place within the home of the mother. In many ways the antenatal preparation can be seen to have prepared women (inadequately?) for the birth of a baby, but not for coping with being a mother. Assumptions around women's natural abilities to do this appear to underpin the ways in which antenatal preparation is undertaken. Once a live birth has been achieved the medical experts begin to disengage and women

are expected to know what to do, having been monitored on a regular basis over the preceding months. For many of the participants however 'mothering' did not come naturally and the early days at home were a confusing and challenging time as the extracts below reveal,

"I'm thinking, 'oh my god, it's a baby, oh god, oh my god...mum's changed its nappy and I'm just looking at it thinking 'oh god'" (Sarah)

"I think I kind of expected to be more in control of the situation and I wasn't really at all. In fact I just didn't know what to do, it was all completely new to me and I felt very kind of overwhelmed by the whole experience" (Philippa).

"I think I have a right to feel upset and tearful because of you know the experience...the enormity of it, I think that's what made me cry in the first place"(Felicity).

Yet although most of the participants found the early days at home a challenging time, not all did. In the extract below Peggy places her own experiences in context,

" it's just like when you get a new dog or a cat or something and you know, settling it in...It doesn't sound very good does it? It doesn't sound very maternal, but.." (Peggy)

What is interesting here is not the apparent ease with which Peggy has settled her new baby in, but her recognition that comparing the settling in of her new baby to what she has previously experienced with her dog and cat, does not 'sound very good', or 'very maternal'. Peggy acknowledges then that there are publicly acceptable ways of narrating experiences of becoming a mother and this description may not be perceived as 'very good'. Of interest too, and showing the complexities and contradictions in accounts, Peggy had earlier commented,

" (antenatal classes) didn't really prepare you for actually what you'd got to do when you'd got the baby..Which wasn't really much use because you just wanted to be told, you know" (Peggy).

The shift in location from hospital to home then marked the beginning of a shift in the relationship between the experts and the mothers. Whilst postnatal health practice is underpinned by assumptions and expectations of

womens abilities to naturally mother, the new mothers in the study appeared to be working with a different frame of reference. They still felt they needed expert guidance and someone to share the responsibility and, at times, take control. They felt confused by this new twist in the relationship as the following extracts show,

"I must admit that one thing I didn't like was that because my emotions were all over the place and I'm a very organised person, I found that it was very difficult for me to get my head round who was supposed to be in charge of me, who I was supposed to ring up and all the rest of it...and I was under the impression that she (midwife) was going to keep coming for ten days, and after the second day she said, you're fine, I won't come anymore. And I have felt a bit abandoned really, and she knew that I was feeling quite emotionally tender, so I think perhaps that could have been dealt with a bit better....and I did feel a bit abandoned...the midwife just dropped me after two days saying that I was fine, the baby was fine and everything was all right..But I didn't feel emotionally all right" (Rebecca).

"And I've found the whole way through that they're fairly reactive but then that's OK, once you get used to it. I think I went ... I kind of had the attitude ... or felt that everything should be a bit more black and white than it actually is and that people would actually tell me what to do, and I've found ... I mean even in hospital no-one told me how to sort of bath the baby for example. I had to you know say how do you do ... how do I do this? And they said gosh, hasn't she been bathed for two days you know or whatever? Well no-one's shown me, no-one's given me a bath or whatever, I don't know. And I think emotionally as well I mean they were quite supportive. The occasion when I'd seen the midwife one day and everything was fine and then she said right I won't come tomorrow if that's all right....have a day off, and I called her and said come round, because we'd had like this sort of 12, I think 12 hours feeding almost continuously right through the night, and I just didn't ... I mean I didn't know what I was doing wrong, whether it was just she wasn't getting enough or whether she just wanted the comfort or whatever. And she was great because she sort of came round and she actually put me to bed and latched the baby on and made me a sandwich ..and I felt quite depressed about you know 'oh my god what have I done' because she (baby) was obviously taking up all my time and all (husband's) time as well and we were both like 'what have we done to our lives?' We quite liked our life before and we were just never going to know ... we just couldn't imagine ever being beyond this kind of 24-hour baby care" (Philippa).

The sense of wanting to know 'who was supposed to be in charge of me', illustrates the dependent relationship which has developed through a protracted period of antenatal support. Ironically it is these early postnatal days that the participants identify as being when they most needed emotional and practical support, when they are struggling to make sense of the enormity of the changes that have occurred. Finding that experiences of early mothering do not resonate or fit with expectations has profound implications for the ways in which these mothers produce narratives. Voicing difficult

experiences is always done within the context of now feeling able to cope, or things now being better. To voice experiences of not coping is perceived as too risky. In the context of mothering being perceived as a 'natural' ability, to admit to 'failure', to not coping, is to risk incurring moral sanctions. The narratives constructed during this period then function to demonstrate that, if they have experienced some earlier difficulties, they are now coping. In the following extract Helen reflects on the antenatal preparation,

"The only thing that I ... I could possibly sort of criticise on now ... I wouldn't say it as a criticism, but I was not prepared for at all for the emotional changes of when you come home and suddenly you're living this story life when you have the baby and suddenly when you come home and after all the visitors have started to dwindle off and it's just you that's left as to how your life is possibly you know going to change, that there is going to be no normality whatsoever.. I suppose I've been you know quite a controlled ... well I was in control of my own life, I knew what I was doing and every day I was quite organised and things, and that's completely gone out of the window. And I would say that I hadn't really been prepared for those feelings of actually being out of control, which I would say probably only the last week that I've actually got on top of it and I'm actually starting to feel a little bit more in control" (Helen)

This participant then tentatively voices some concern 'I wouldn't say it as a criticism' of her antenatal preparation. But crucially her voicing of earlier difficulties is within the context of 'only the last week...actually starting to feel a little bit more in control'. To admit to, or to actually experience feeling out of control, may mean that it is impossible to construct a coherent, or publicly recognisable, narrative (see Chapter 7). The difficulties of voicing a need around mothering appears to be particularly difficult. To admit to those perceived to be experts that your experiences of mothering are problematic has all sorts of implications for how women are perceived. Whilst some participants talked of their difficulties of asking for help, others spoke of the competing perceptions of 'normality' in the early weeks following the birth of a baby.

"They're really worried about postnatal depression, she's really hot on it. And she did keep trying to tell me that I was postnatally depressed, when I don't think I was...I was in floods of tears continuously ..and I think it was just normal" (Sarah)

"Midwives came for 10 days, well the 10-day period, this is another thing. Because I felt so dreadful I would have liked them to call every day to check sort of my tail end every day, but they assumed that because I was again ... I suppose they think this is a fairly nice house, you know you've got everything sorted out, (husband) was home, they kept saying 'I'll not call tomorrow eh, I'll leave it for a day or two' and I kept ... it was almost as if I couldn't say no actually I want you to come back and talk to me tomorrow. So I had to go OK yes, that's fine" (Felicity).

"But I still felt as though it wasn't normal somehow to feel like that...you know my whole life's falling apart and I can't do anything and they're (other mothers) coping so well" (Diana).

In a later extract Diana talks of her fears of being perceived as not coping and being labelled by the experts as,

"postnatally depressed, we're going to take the baby off you, and that's something I did worry about" (Diana).

The irony here is that a friend of Diana's, who was also a participant in the study (Helen), was also experiencing difficulties, yet neither felt able to voice these to each other. The myths then of how women should feel and act on becoming mothers are perpetuated, women feel vulnerable and unable to challenge dominant ideologies of early motherhood. As Helen recounts in the extract below,

"I suppose I've been you know quite a controlled ...well, I was in control of my own life...and that's completely gone out the window...and I would say that I hadn't really been prepared for those feelings of actually being out of control" (Helen)

Helen then (unknowingly) shares some sense of her life being out of control, 'falling apart', with her friend Diana, yet when she relates that the midwife had found her to be "bordering on post depressive", according to the Edinburgh postnatal questionnaire¹, she asserts that,

"I actually do feel a lot better now, I'm starting to feel in control" (Helen).

¹The Edinburgh Postnatal Scale (see Appendix 1) has been designed in questionnaire format "as a screening tool for the detection of Postnatal Depression". It is administered to mothers by Health Visitors at between 6-8 weeks postnatally.

A sense of being in control then, of having regained control implies that life can begin to return to 'normal', perhaps that aspects of a previous life start to become visible again.

A Shifting Sense of Self: Being a 'Mother'.

A narrative turning point occurs when experience replaces anticipation, leading at times to a reordering of past events. The biological act of giving birth means that in a very short space of time women shift from being pregnant and anticipating motherhood, to being mothers with a dependent child. Yet this biological shift is not always mirrored by such a swift ontological shift. Beginning to feel like a 'mother' is often a much slower process. Women can find it difficult to reconcile the differing biological and social time frames which exist around mothering. The potent ideologies which surround perceptions of motherhood together with the biological act of giving birth do not in themselves mean that women feel like mothers on the birth of a child. And yet as soon as a child is born, women are seen as mothers by all those around her. The identity of mother appears to override all others.

A loss of control in women's lives, coinciding with the transition to motherhood, has been identified as a recurrent theme running throughout and across the accounts collected in this study. The participants had all been working women, most in professional occupations and spoke of having control in their lives and sometimes control over others at work. The experiences of pregnancy, the birth and the early weeks at home had all contributed to a perceived loss of control in their lives. At the time of these early postnatal interviews most of the participants were trying to come to

terms with, to make sense of, the enormity of the changes in their lives. The following extracts show their struggles,

"my role in life has changed...I mean I was saying this to (friend) yesterday, I don't really know who I am yet...There isn't anything in my life that I could say is any sort of constant stability to ...in reflection to what it was before" (Helen).

"the change to my life I think is complete and absolute, there's nothing left of my life that resembles...I have (baby) all the time and it doesn't matter how much you love your baby, if you've had a life its very difficult to give up all of it, and I think I started to get really resentful because I was struggling to cope, just generally day to day I just felt like she demanded all of my attention all the time. I couldn't do anything for myself" (Diana).

"you realise what a totally different you know, you're in a different world at the moment, you know.." (Lillian).

"I felt as if I didn't have control over what was going to happen to me anymore" (Felicity).

"although she's...I mean she's never been a problem, but I'm certainly as I say the last couple of weeks been thinking that there's more to life sort of thing... the last couple of weeks I've sort of felt that I can do more" (Faye).

This period of transition 'a different world at the moment', which lacks any 'constant sort of stability' is differently experienced by each of the participants as they each try to come to terms with becoming a mother. The early postnatal period is characterised by both internal and external changes, one participant talking of being in a different world at the moment, and another of not knowing who she really is yet. It is interesting that Faye pre-empted her acknowledgement that over the last couple of weeks she has felt that 'there's more to life' with the qualifying sentence "although she's...I mean she's never been a problem". Feeling able to cope, of regaining control, provides a turning point in terms of narrating experiences of the early weeks, yet actually identifying with being a 'mother' is something that for some of the participants is only much later acknowledged (see Chapter 6). In the following extracts the participants acknowledge types of mothers, but they are not categories they can yet identify with,

"I don't really see myself as kind of an earth mother type... I still don't really think of me as a mother a lot of the time, you know I think of me as looking after (baby) ..but in terms of my mothering skills, I'm not sure...I'm quite keen to keep some sense of my pre-baby self" (Philippa).

"I'm beginning to feel like a mother, but that's only recent (baby 8 weeks)...but there are some bits of my life that I miss...it didn't come naturally" (Diana).

"I've tried to maintain that sense of self, but I know there is this...that I will always be perceived as a mother...but when I go out I try not to look mumsy and I think that's partly to do with how I feel about myself" (Felicity).

"I've only just started saying 'my child, my baby' (13 weeks) But I don't know if I feel like a mother. I don't know what you're meant to feel like" (Sarah).

"I mean it's like how do you define a mother? Yes, I'm doing all the practical things of a mother. But it hasn't actually sunk in...It's like I'm living this part in a play and in fact I'm going through all of the motions, but is it actually reality and is this what motherhood is all about? You know, my mum's a mother, but am I?...although you probably ask anybody that knows me and they'd say oh gosh, she's like a duck to water and she's very natural and relaxed with her and it just seems like I can't ... you know I can't have life without her. And that's ... is how I do feel, but I wouldn't say, no I wouldn't say that I really feel like I'm a mother ...I was very ready to become a mother, Mother! but in fact I have lost control of my life" (Helen).

In the above extracts the doing of mothering work, doing 'practical things' and 'looking after' are identified by some of the participants, but are seen as distinct from being or feeling like a mother. Some women at this time were struggling to hold onto a sense of their selves, and their lives prior to the biological act of giving birth. Yet whilst they may struggle to make sense of this period of intense transition, especially if they do not find mothering to be 'natural', others around them identify them immediately as mothers. In the extract above, Helen talks of others' perceptions of how she is coping as a new mother, "like a duck to water" and that she's a "natural". The difficulty then for Helen, and other women whose experiences do not resonate with their own earlier expectations, is feeling able to reveal that internally they are struggling. Helen uses the analogy of living a part in a play, the implication then is of pretence, of 'going through all of the motions' but not actually feeling, as she thinks she should feel, like a mother. The complex interplay between ideological assumptions and the social construction of motherhood are evident in these extracts. Narratives are constructed within the context of mothering being perceived as 'natural' and mothers being guided by 'instincts'. When these are not experienced, struggles in narration may be

experienced. Paradoxically, the context in which motherhood is experienced can also make it very difficult to voice unhappy experiences and those perceived not to resonate with the experiences of others.

Other participants spoke of their sense of themselves as mothers.

"I walked in I said 'all right mummy's here'. And I thought 'oooh', it sounded so wierd to be saying that. But yes, I do thoroughly enjoy being a mum" (Sheila).

(feeling like a mother) "I suppose so, I don't really feel any different you know...well I suppose...I don't know really what a mother feels like. I mean I suppose so, but you know...I don't really have time to sit there thinking what I feel like. Yes, I suppose so....You get on with your life and you get on with the baby and you just do it" (Peggy).

(feeling like a mother)"Yes, it's come really naturally to me which I wasn't sure whether it would or not...but then I think that because we planned it all and we knew what ...that this was the right time..It wasn't too early and we were ready for it" (Faye).

The extract from Faye is interesting because she had earlier asserted that only in the "last couple of weeks (she'd) been thinking that there's more to life sort of thing" the implication had been that she was now feeling more able to cope and to get out, yet in the extract above she talks of mothering coming 'really naturally', implying she had not experienced difficulties. The complexities and contradictions in producing narratives then becomes clearer. Similarly Diana also talks of the range of emotions she has experienced since having her baby,

"a lot of people probably feel the same, but I couldn't believe how invisible I became after I had her" and later "I can't believe how happy having a baby has made me feel, even though it has made me extremely unhappy at times" (Diana).

The transition to motherhood for most women initiates changes in a sense of self(s). Whilst many of the women spoke of trying to retain a sense of their 'pre-baby self', Sheila talks of not having changed,

"I mean I am responsible for these two, but me personally I don't see anything different in me, I haven't changed as a person I don't feel. I'm still as stubborn as I used to be" (Sheila).

Yet later Sheila talks of her life in the following way,

"My whole life revolves about them now...I rule them actually, they don't rule me. I rule them...so my life is totally different to what I actually thought it would be" (Sheila).

What these extracts show are the complexities of perceptions of a sense of self, the 'me' being experienced as different to 'my life', and yet for many people the threads of a sense of self and a life are inextricably interwoven. Becoming a mother then is inextricably bound up with shifts in a sense of self/selves.

Being a 'Real' Mother in the Public Sphere:

The process of feeling like a mother was for some participants a very gradual process and had implications for their interactions in both the public and private spheres and their presentation of self. So, whilst dominant 'public' and 'meta' narratives (Somers, 1994) may have repercussions for the ways in which individuals construct narratives, they may also have repercussions for individual's interactions. From the data collected it became apparent that the maintenance of a coherent/ recognisable narrative of being a mother may be easier to sustain in certain contexts, in this case in the private sphere of the home. For some women the discrepancies, which were found to exist between expectations and experiences of becoming a mother and the resulting difficulties in making sense of the enormity of the changes they were experiencing, could largely be managed within their own homes. However concerns about being perceived as a competent social actor, a 'real' mother, in public places, influenced social action in the public sphere. Interestingly, withdrawal from social networks has been identified as a factor in the development of 'postnatal depression' (Mauthner, 1995). In the following extracts some of the participants relate how, because their experiences of early motherhood did not resonate with their expectations and in most cases they did not actually feel in control, or like 'a mother', they regulated their interactions in public spaces. The dangers inherent in being

visible in a public place and not projecting an identity of 'good' or 'proper' mother was for some considered too risky, and they confined themselves to the perceived safety of the home. In the following extract, Philippa talks about the exhaustion she has felt since the birth of her baby,

"so I didn't go out very much which really made it hard...I don't think I went out, literally set foot outside the door for three or four weeks or something which is quite...it was a long time, and that was too long actually, because I didn't ...but I just felt...I didn't feel very confident taking her out because I just thought she was going to cry the whole time and I felt a bit sort of self-conscious about it I suppose and I thought at least at home I can always feed her and I didn't feel confident about feeding her out of the house and things...I mean even now I sort of feel if I take her out shopping and she started crying ...this women in a shopping queue said to me 'they hate shopping', and they're so sort of accusing and I felt like saying 'well I have to eat'...I mean I am sure she didn't mean it like that, but I took it as you know you're inflicting this awful thing on your child. But I mean I sort of feel I get disapproving glances. I'm sure you don't at all, but I can't...that's how I interpret it". (Philippa).

Concern about coping and being perceived as a 'real' mother in the public sphere is a theme which emerged from other participants' interviews. In the following extract, Felicity relates an early outing to the doctor's with her young baby,

"...we had to go to the doctor's and both of us went, Robert and I went with the baby and then I got a prescription. Robert went to get the prescription, I said I'll come home because the estimators were coming for the removals. And I'd done ...you know I'd got one of the changing bags like you're supposed to, taken a bottle of milk with us in case he got horrible, and he had in the doctor's and Robert had started to feed him and then we'd left and he was quite happy. But I was coming home and he started to get hungry again and Robert had the bottle in his pocket and had gone off to the shop to get the prescription, so I had this screaming child in the middle of [town] on, I think it was a Thursday afternoon, and it was hot and the tourists were there, and I felt like shit and I couldn't walk very fast, and I had to virtually run from the middle of town to here, over the bridge, and you could tell everyone was 'poor child', 'what's that woman doing with that child'. And I thought, I was convinced somebody was going to like stop me and say you've pinched that child, that's not your child, you aren't a mother, you don't look like you can cope with him, this baby, you should be doing something to stop it crying" (Felicity).

Extracts from other participant's early postnatal interviews also contain the interwoven themes of confidence and feeling in control,

"but it's absolutely exhausting, yes, I was quite sort of lonely to start with when he wasn't doing much and I didn't really feel confident enough to go out" (Clare).

"but it's taken eight weeks to be confident to walk along with a pram with a screaming child" (Abigail).

"I know I'm a mother but I don't quite feel like a mother yet...I went to [shop] once and she screamed the whole way round, then I did feel like a mother because all these old ladies were there and they were going ...'that baby shouldn't be out', 'it's too hot for that baby to be out'. I could hear them rabbiting on behind me. So then I did feel very much like a mother...a dreadful mother" (Gillian).

"I know sort of how long she can go without food so if I want to go down Town or something I can sort of time it...so I don't have to feed her when I'm out" (Faye).

"You know you just feel so tied to this one little thing, and tied to the house, just ... and also I think because I'm ... I'm so organised and such a ... like sort of things well planned, I found it impossible to be able to make appointments...I was never quite sure when he was going to feed and when he was going to sleep, and I think because I couldn't control him I was worried about making any appointments whereas now I think well I'd take him with me and if he cried so what...whereas at the beginning I think I thought if he cried it was my fault and I was very aware of people thinking you know he's crying, why doesn't she pick him up ...and that made me feel guilty. There's this awful guilt sort of ... oh, it's dreadful" (Kathryn).

Clearly then, striving to make sense of the intensely private experience of becoming a mother, within the context of public expectations, is both challenging and potentially baffling. Difficult experiences may remain unvoiced and social action be regulated. Concerns about being perceived as a 'real' mother were also implicit in three accounts where participants felt that their 'pretence' to being a mother/ parent would be found out. In an extract above Felicity talks of her fear that others will think that she has 'pinched' her child, and this theme of a child not really belonging is a recurrent theme,

"But I still feel I've borrowed him, that I'm not his mother, that he's not mine" (Kathryn)

"We kept looking at them and thinking no, somebody's going to take them away because they are not ours really" (Sheila, mother of twins)

"Coming home with him was odd in that we both felt that we'd kidnapped him and even though I'd been pregnant, it didn't really feel right. But we were both very natural with him. So there was complete conflicting things, that we must have stolen him but he was ours and we coped with him really well. It was really odd...really bizarre, freaky" (Abigail).

Becoming a mother then is bound up with shifts in a sense of self/selves, or gradually feeling confident and competent as a mother both within the context of the private responsibility of childcare in the home and in more public spaces.

Anticipating a Return to Work.

Movement in the public sphere, specifically the world of work was seen by some participants as offering the possibility of a return to their pre-baby self. Work outside the home was seen as a domain in which they could return to their working selves, somewhere where they were not 'just a mother'. In the following extracts, participants talk of their wish to return to work outside the home,

"I just adore them totally but it is, I think you need it" (Sheila).

Others talk of their need to return to work,

"that's why I want to go back (to work) is to be me" (Abigail)

"I'm looking forward to it in a way 'cos it will give me a break I think 'cos it's surprising how much work it is, you're on the go all the time, I think I have about an hour (a day) to myself" (Angela)

"because I think work, well for me it was very much a part of my identity, it's part of who you are, and I think that I didn't really realise that until I didn't have it, and having the baby has made me realise I do need something back for myself, because I have lost my identity - to everyone else I'm Sonia's mum and that's what I am, who I am, and I don't think I will regain any of that feeling of having my own identity until I get back to work which is why it's important I think for me to go back to work. I'll never be the same because I can never be at work what I was before because I'm still Sonia's mum, but I will always have something a bit different, something for myself and when I get back to work I know that I will have something for myself like I'll go to the gym when I'm at work and I'll chat to people and I'll have a bit of a laugh and I'll talk about things other than babies, but then I'll come back and I'll still be Sonia's mum and I'll still have to get up in the middle of the night or change dirty nappies and talk about baby things on the days when I don't go to work, but that's OK as long as I've got something for myself, I couldn't ... I couldn't survive without having that I don't think" (Diana).

"I'm not sure that I am cut out to be a full time mother...I don't know that I'd find it stimulating enough...well not stimulating enough, but...I don't know really whether I would be good at it..I need to do both anyway I think" (Philippa).

Clearly then, some of the participants see their return to the world of work, outside the home, as offering an opportunity to regain their identity, which is felt to be either 'lost' or submerged in full - time mothering. One mother spoke of her satisfaction with being at home with her baby daughter,

"so the future at the moment just for me, I'm just concentrating on Emily at the moment I'm afraid. I've just not really thought about what I'm going to do" (Faye).

Yet interestingly Faye finds it necessary to apologise "I'm afraid" when she voices apparent contentment.

Concluding Discussion.

Narratives produced during these early postnatal interviews are both complex and contradictory. Whilst women tentatively construct and produce narratives of anticipation during the antenatal period, the experience of giving birth and being responsible for a child precipitates both an ontological shift and a narrative turning point. Narratives of mothering become grounded in experience which may differ from, or challenge, previous expectations and other knowledge's which permeate motherhood. A struggle may then ensue during which women attempt to reconcile their own experiences with their earlier expectations and assumptions whilst presenting as a coping and 'competent' mother. At the same time the nature of the interaction with medical and other health professionals shifts during the early postnatal period. No longer supported by the 'symbolic resource' of the medical model (Bury, 1982), the regular monitoring experienced during the pregnancy and birth is reduced. Women are expected to 'naturally' know how to mother (Lupton, 1994). The process of disengagement is perceived to occur soon after the birth of a baby, even whilst in hospital according to some of the accounts collected. Yet women experienced confusion as the process of

disengagement began, wanting to know who was in charge of them. Whilst they had largely 'collaborated' (Reissman, 1983; Fox and Worts, 1999) with the experts during the antenatal phase their expectation was that the relationship would continue. Many of the women wanted those they perceived as experts to tell them what to do. The act of giving birth did not necessarily, or often, lead the participants to identify themselves as 'natural' mothers or childcare experts, rather they experienced confusion and struggled to produce recognisable narratives of mothering when they had not yet had time to develop a 'mothering voice' (Ribbens, 1998). Almost overnight they were expected to become the experts on their child, and whilst over the early weeks most of the women felt able to fulfil what they perceived to be the practical aspects of mothering, many did not recognise themselves as mothers. The health professionals and the new mothers can be seen to be working with competing frames of reference. The enormity of the changes that had occurred and were being lived through were interpreted differently by the new mothers and the health professionals. When difficulties were experienced, some participants felt unable to ask for help as they thought they should be seen to be 'coping'. To ask for help was to admit to not being a 'good' or 'real' mother, not a 'natural' mother. And so the myths surrounding transition to motherhood are perpetuated. When difficulties were described it was always in the context of things now being better, 'fabulous', under control. So when narratives contained experiences that could be seen to challenge dominant ideologies of motherhood, more publicly recognisable ways of talking about being a mother would also be incorporated. To produce an account of early mothering which did not in some aspects resonate with perceptions of what being a 'good' mother was all about - and the women's own anticipatory narratives - involved too much risk. The process of negotiating and narrating experiences of early motherhood involved reconciling unanticipated experiences and potent

ideologies. (It is only in the final interviews and the end of study questionnaire that such experiences can finally be voiced, see Chapters 6 and 9 and Appendix 8).

Problems then can arise when an individual's experiences cannot be accommodated within the available range of multi - layered public or lay narratives, and as Somers states, "struggles over narrations are thus struggles over identity" (1994:631). Whilst difficulties could largely be managed within the safety of the home, the public sphere was perceived as presenting greater challenges. For some of the women concerns about being able to present as a competent social actor, a 'real' mother outside the home, led to their restricting their interactions in the public sphere. The control which they had felt they had in their lives as working women had been challenged, and for some lost, as they tried to accommodate and make sense of the ontological shifts which they were experiencing. A return to the world of work was seen by some to offer a way out of this period of enormous transition, as offering an opportunity to return to their 'pre-baby self' and regain control.

Transition to motherhood then takes place within the context of powerful ideologies, which help shape expectations, and assumptions around women's natural abilities to mother. Experiences of early mothering which do not resonate with the accounts of others, or do not appear to fit within the limited repertoire of acceptable motherhood stories are difficult to voice. The perceived need to produce a coherent and socially acceptable narrative appears paramount, to produce something other would have unacceptable implications in a society where motherhood is all about being a moral person.

Chapter Six

Narrative trajectories: becoming the 'expert'.

Introduction.

The final interviews were carried out at between eight and nine months postnatally. Access was renegotiated by telephone and interviews were mostly carried out in the participants' homes. To initiate the interviews I would remind the participants of what we had spoken about when we had last met, which for some was more than seven months previously. One participant had moved out of the area during the months preceding the final interview and despite efforts, I was unable to re-establish contact. Another participant who had felt unable to be interviewed during the early postnatal period opted to re-enter the study for the final series of interviews (see Chapter 7).

The narrative accounts collected during these final interviews stood in contrast to those collected during the previous interviews. Nine months after the birth of a child, the participants were able to organise and present sometimes challenging narratives of mothering, to reflect and place their transition into some sort of order, which may not have been experienced in that ordered way. The passage of time had enabled the women to make sense of their experiences of becoming mothers, whether this was to affirm their positive experiences or to enable them to challenge dominant ideologies surrounding motherhood. Retrospectively, difficult experiences could be disclosed for the women could narrate their experiences from positions of strength, as the experts on their own babies. Survival now enabled them to challenge some of the taken for granted assumptions which exist around mothering. The shift to position of expert and the consequent reordering of

perceived expert knowledge was only gradually achieved and related to differing notions of a return to 'normal'. This in turn was linked to the almost total withdrawal of medical/ health professional interaction and a confidence in one's own knowledge as a mother to challenge professional advice which was not welcomed. The function of the narratives then was not to present as a coping and 'good' mother, as in earlier interviews, but rather, from a position of ontological confidence, to challenge and finally reveal earlier experiences which, as lived, were too difficult/painful to voice. Distance from the experience facilitates narration, for as Frank has noted, "for a person to gain such a reflexive grasp of her own life, distance is a prerequisite" (1995:98). As in the two preceding chapters, the substantive issues of (dis)engagement with perceived expert knowledge and the shifting sense of self(s) as women move in and out of the different 'worlds' of home and work, will serve to illustrate the shifts which have occurred since the birth of their babies.

Shifts in Perceptions of Expert Knowledge:

Whilst the early postnatal period was characterised, for some participants, by uncertainty and the desire to be told what to do, the narratives constructed in these final interviews demonstrate a shift in perceptions of who holds expert knowledge. The dependent relationship developed during the antenatal period had given way to women being confident in their own knowledge of their babies needs. Indeed the disengagement which was perceived to occur postnatally by some of the participants in their previous interviews could now be interpreted as having fostered independence. And whilst the underlying assumptions which underpin health professional practice, that is that women naturally know how to mother, can be seen to differ from the experiences of the women themselves, gradually women do become more

confident in their own abilities. In the following extracts Abigail and Helen talk of their growing confidence,

"I don't feel that I need information as much now because I don't know it all obviously because he is still only eight months old...but I do feel that for most stuff it's common sense. The stress goes out of it... you become less dependent on others because your own confidence builds...it's so easy with hindsight ...somewhere along the lines it all clicks" (Abigail)

"I think I feel a lot more sort of secure about myself and my decisions and what's the right thing to do and what isn't...so, yes, but I'm certainly more confident now" (Helen).

Diana describes the changing relationship in the following way,

"they (health professionals) just disappear don't they and they suddenly just are not around... I find it quite amazing that they can be so in your face for like weeks and then just not there" (Diana).

Growing confidence in being more knowledgeable than others about their own child's needs leads the women to challenge those they had previously regarded as experts. In the following extract Sheila describes the gradual process of reaching a point at which professional expert knowledge and advice can be challenged and discarded,

"That was, that's been my real ...I don't know, it's just you don't know what you're doing...I always like to have, 'this is what you're doing' and I'm told and then I just do it. But with solids and everything, you just don't know what you're doing. You have to feel your way...on their eight month check they are supposed to sit up, they're supposed to put their hands up to be picked up, and all these things they're supposed to do, and I just think, oh, I just don't care anymore. If they don't want to that's it, that's their little way of doing things. I know they're perfectly happy, healthy children. And that's what, you know, I've come to realise" (Sheila).

Sheila goes on to describe another occasion when she received advice from the health visitor,

"She said you know, 'oh you really should be giving them finger food because some children will get tactile' and I said, 'what do you mean' and she said 'oh well, they don't want to touch things'. So, I was like getting all uptight thinking oh, maybe I should be doing this thing...and then I just thought 'oh, sod it, I'm just going to do what I feel and what's handy for me" (Sheila).

What is interesting in the above extract is the use of expert language 'tactile' and Sheila's initial concern over this, 'getting all uptight' but eventually

feeling able to weigh up the advice in the context of her life, and reject it 'oh sod it, I'm just going to do what I feel and what's handy for me'. Peggy also talks of challenging expert advice concerning weaning her baby on to solids,

"I started him at 15 weeks with the health visitor having kittens (she) kept saying you've got to wait until he's 4 months old and I said well look I can't wait" (Peggy).

Unusually, after a relatively short period of mothering (15 weeks) Peggy feels able to act in a way which is counter to the expert advice she is being given. But this action must be seen within the context of other information Peggy has, as she explains,

"apparently my mother had the same problem with me of not putting on weight and getting nagged at all over the place, so she said 'don't worry about it'" (Peggy).

Supported by her mother whose knowledge is seen to be grounded in experience, Peggy is able to reject the professional advice given. Other participants spoke of finding support from other mothers whose advice is similarly grounded in experience as mothers, and of feeling more confident in their decision making. In the first extract Faye talks about a mothers' group she has joined,

"which has been quite good because we talk about things" (Faye)

"yes, I haven't relied on the health visitors or the ...or even the doctors" (Rebecca)

"I met a couple of girls through a postnatal group which I went to once because I felt I had to, and we've become quite good friends and I tend to see them you know every other week or so, and that's more helpful than the health professional I find, but no, I haven't ...I haven't seen anyone. You know you never see hide nor hair of them they just disappear don't they?" (Diana)

"The health visitors are on the whole...certainly at the beginning were really good. I find now that he's older and therefore probably not prone to as many problems, I'm more experienced...And I think you know girlfriends, I tend to sort of ask them what they're doing far more than health visitors or professionals think I'm much more confident now. I mean I...I think as a mother you just have an instinct and you know what's right" (Kathryn).

"I've got used to the idea now and it's coming more naturally...you become less dependent on others because your own confidence builds" (Clare)

"when she was about 4 months, I sort of stopped seeing them as frequently. I kind of had her weighed a couple of times. She had a hearing test and things and I've seen one health visitor once since I've been back to work. And they've been fine actually, you know there's

no ... I mean not ... I think because you kind of go through the whole thing with your health visitor and your midwife to start with it's like ... and they're much more involved it's not the you know I just ... just sort of go along so they say she looks well, she's gaining weight and that's it really... I mean I just don't have any worries about her really and I think, I know that I'm doing the right thing in terms of with feeding. I'm not worried about her developmentally. It seems fairly kind of common ... a lot of common sense to me at the moment...Yes, I mean it's partly confidence and it's also ... I think it's kind of easier. She seems like a more kind of robust being rather than this kind of fragile little thing ... And also because she goes to nursery as well - this sounds really awful but I sort of think there are more people involved, it's not just me anymore" (Philippa).

It is interesting that whilst Philippa welcomes the shared responsibility of child care now that she has returned to work and her daughter attends a full time nursery, she believes that 'this sounds really awful'. Clearly she feels that mothers are not supposed to enjoy sharing responsibility for their child with others. The implication then is that 'good' mothers take full responsibility for full time child care, a perception grounded in biological determinism and assumptions around women's natural abilities to mother. To reject this then is perceived to sound 'really awful'. However, this is acknowledged and shared with me.

Shifting Sense of Self:

By the time of the final interviews many of the women had returned to paid work outside the home. A return to paid employment involved movement in and out of different worlds and was seen to present opportunities for the women to be 'themselves' again. Interestingly, it was two participants who had not returned to employment outside the home who alluded to the different worlds of home and work. In the following extract Sheila talks of not having any 'out life',

"My outlook on life is totally different. I still don't have any out life, any life of my own really...I miss the conversation, that's the major thing...I mean I love them dearly but I do miss..I mean not just normal conversation, I miss the office life" (Sheila).

But she places her decision not to seek work outside the home within the context of doing mothering in a particular way,

"I really want to be there for them, the old fashioned style isn't it?" (Sheila).

Sheila then goes on to assert her happiness in her current situation,

"I'm quite happy at home, I'm my own person now since I've got these (twins)...but I still want my..my independence" (Sheila).

Yet the contradictory and complex nature of narratives is clear throughout these extracts, as Sheila asserts that she's her 'own person' which implies autonomy and independence, but goes on to say that she still wants her 'independence'. Faye also rationalises her decision not to seek work outside the home, which results in her feeling a 'bit out of the world',

"I wouldn't earn very much and I don't know whether ...I know it would be for my sanity, but I don't really want to work to pay someone else to look after her... I sometimes feel a bit guilty about not going to work...you..sort of you feel a bit out of the world in a way because you're not getting up every day and going into work and the normal things you do" (Faye).

Work outside the home then is seen to offer the possibility of 'normal things' and to help maintain 'sanity'. Choosing not to work outside the home engenders some feelings of guilt, yet joining this other 'normal' world also engenders feelings of guilt as the following extract shows,

"the mixed feelings I had about going back to work - on the one hand I did want to go because I ... I did miss the sort of wideness of the world, you know the world becomes very small when you're at home with a baby because it's a baby isn't it and other mothers and it's not really ... you don't have much to talk about. And ... but on the other hand I felt that you know should I be leaving this baby who probably needs its mother more than anyone. Very mixed. But then I was lucky to be in a position to go back part-time, so you feel you can balance it a bit. You've got some work and some time with Sonia, but then the downside to that is that you ... as I say you just feel you're not doing anything...constantly feeling guilty, under achieving...under achieving mother, under achieving employee...I'm very organised and like to be in control and it's just never ...you're never going to be in control again" (Diana).

A return to the world of work was always contemplated by most of the participants and is embraced as a means of temporary diversion from their otherwise all consuming mothering role. Abigail explains her readiness to rejoin the other world,

"I do like being a professional person and myself...I really felt by the end of my maternity leave that I was treading water and the whole world was getting on with their lives and mine

was on hold...Even if I was achieving something with him, I didn't feel it was enough for me. That might sound selfish, I don't know?...I felt so trapped by the end of my maternity leave, I felt so isolated" (Abigail).

Abigail tentatively voices her experiences of motherhood which 'didn't feel enough for me', yet recognises that this might not be perceived as an acceptable way for a mother to narrate her experiences of mothering, and adds, 'that might sound selfish'. Other mothers also spoke of mothering not being 'enough' for them.

"I kind of thought I'll go back, never really kind of found myself like a real role as a mother, like a role just me and Georgia in the house together, we were fine, but I just ... that wasn't enough for me obviously. I mean I needed to see other people, I needed to make new friends, and I haven't really done that so I haven't really established myself as a kind of a social being outside the house you know. And I was starting to think you know this is not enough for me really and I need more stimulation and adult company and things" (Philippa).

"I still sort of want to get a part of my life back and not just talk nappies...it wasn't really me going to parent toddler groups all the time...I mean when I'm at school I'm more my old self" (Clare).

"I felt as though if I had a job I was doing something, whereas if I didn't, if I was just at home with baby, 'oh you're just a mother and a housewife'. And I know that's the wrong thing to think but you still can't help thinking it" (Rebecca).

The 'value' of mothering and the pervasiveness of the contradictory messages which surround womens' lives are clear in this last extract. To be 'just a mother' and 'just at home with baby' is not perceived to be enough and Rebecca acknowledges that her feelings are linked to the 'status thing'. Others have not established themselves as 'social beings' outside the home as a mother. The (inaccurate) perceptions of what other mothers are like, and do, are not challenged by these women but rather help to underline decisions made to return to work. Several of the women spoke of types of mothers who they saw around them, but with whom they did not identify. In the following extract Wendy talks of meeting other mothers who do not work outside the home,

"..and you talk to them...they are so boring, they've got nothing to talk about. I mean god, I don't want to become one of them...I don't want to end up like that" (Wendy).

Clare and Abigail also talk of mothers needs to meet together and talk, but distance themselves from such activities,

"I mean being at home all the time you want to get out and meet people and you...So, I can understand why people do, but it wasn't me" (Clare).

"I only ever palled up with with one other (mother) and so once a fortnight. once a week, we'd have a coffee morning, but it was so focused on our children. How many teeth have you got? How many farts does he do, anything, oh for god's sake, what texture is...for god's sake, I don't want to know. So it's nice to have got away from that" (Abigail).

A return to paid work, the 'out world' offers the opportunity to re-enter a world in which the women operated before they became mothers. In their jobs they were competent social actors whose performances were measured according to criteria not usually as ambiguous as those which operate around mothering. They were seen to have specific work skills which are more highly prized in a society where mothering is regarded as natural and therefore less valued in a capitalist society. Ironically a return to work was regarded by some to be the easier option, as the extracts below show,

"I mean I admit this to you and it'll be on the tape, but at the end of the weekend I'm thinking 'phew! thank goodness somebody else has got part of the day', which is an awful thing to say maybe?" (Kathryn).

"I do enjoy being a mother, I am enjoying it a lot, although I find it incredibly hard work. Having said that I do like being at work" (Diana).

"I just sit there all day, like you've got a computer in front of you and it's...we're on a good section so..it's just good. Yes, I get away from the babies and I appreciate them more when I pick them up. Got my life back" (Wendy).

"I think it...it is nice to go and do some work but the thing is at the moment I'm not happy with where I am. I don't know if it's just temporarily you know that it's not a very nice atmosphere, but I still think it's good you know to do something" (Lillian).

Most of the women found that a return to work enabled them to regain their own identity outside of being a mother, and some admitted that they sometimes forgot they were mothers when at work,

"I think ... again, when I was at home with her for a long time I did feel that my identity was being a little bit kind of subsumed into this kind of fluffy thing that included her and me and ... that I didn't really have a life of my own other than my role as a carer for Georgia" (Philippa).

Later Philippa comments,

"Actually a lot of the time I don't feel as much like a mum as I ...as I used to as well you know because I do genuinely forget about...it's awful, but I forget about her when I'm at work" (Philippa).

It's interesting that Philippa thinks her admission might incur judgement and censors herself with the words, 'it's awful'.

Perceptions of Self as a Mother:

When asked about their feelings on becoming a mother in the earlier postnatal interviews (Chapter 5) many women spoke of coping with the practical aspects of mothering but had ambivalent feelings about actually feeling like mothers in those early weeks. Many were still coming to terms with the, for some, unanticipated enormity of what becoming a mother entailed. Yet during the earlier interviews women could be seen to juggle their contradictory feelings and attempt to make sense of the confusion they were experiencing and to confirm that by the time of the interview they were 'coping'. As Diana had commented "I'm beginning to feel like a mother, but that's only recent...but there are some bits of my life that I miss...it didn't come naturally". By the time of the final interviews an interlude of eight to nine months had elapsed since the birth of their children, and experiences remained varied. Interestingly, some participants who had spoken of their immediate, 'natural' identification with being a mother now produced contradictory narratives of their experience. In the following extracts Faye's words from the two interviews are juxtaposed,

"yes, it comes really naturally to me which I wasn't sure whether it would or not" (Faye, early postnatal interview)

"I don't know, how does...how does a mother feel?...No, I don't really consider myself as...I suppose when she starts calling me Mum or something like that" (Faye, final postnatal interview).

The precarious properties of narratives are demonstrated in the above extracts. As individuals we constantly reconstruct and produce narratives to make sense of experiences within the context of other influences. What is interesting in the extracts from Faye's interviews is that the elapse of time has enabled her to challenge taken for granted assumptions around womens' natural abilities to mother. Having survived with her child to nine months, she is able to narrate her experiences in a less publicly recognisable way and question how 'a mother' should feel. Other women spoke of their complicated and contradictory feelings in relation to being a mother. The extracts below illustrate the changing sense of self which is negotiated and narrated as women make sense of their experiences of becoming and being mothers,

"I worry about it the whole time. You know I worry whether I'm a good mother, whether...whether I've got the right responses, whether I'm bonding enough with him...That's what ... this is the bit ... that comes back to the bonding thing, no. I ... I don't know. No, I don't ... my self-image hasn't changed. I don't feel ... I don't know whether I do feel like a mother? No. And that's ... that's what worries me is that ... I still think ... I still feel that I borrowed Rupert. It is... I still feel that he's not mine. That it's like baby-sitting, that I can ...I'm going to be able to give him back, that he isn't mine, and this is the whole bonding thing, and it really worries me" (Kathryn).

"I think I actually half expected that I was going to be an instant mother because I was so ready for it and so looking forward to having her. That really isn't the case at all... I suppose the basics are that I am (a mother), this is my new role" (Helen).

"But I've really enjoyed the whole thing. I'm obviously a lot more maternal than I thought I was...I think I've recognised something in myself you know, perhaps a sort of need to care for something...it's harder than...I don't know, its easier and harder" (Peggy).

"Sometimes I do but I ... I don't know. I mean I do because ... in the sense that I know that Sonia is definitely my priority, but other times I keep thinking am I really a mother, and I've felt like that from the beginning, is it really ... is it really me? You know you just sort of don't really think you're grown up enough to be it, but as time goes on you realise you are because you have to cope with so much more every day, there's always something else, and

you become more sort of mature I suppose. So yes, I do feel like a mother, very mumsy" (Diana).

"The reality of realising I was a mother came gradually. Being a mother I think instinctively happened. I didn't ... it was a bit weird the first couple of weeks because you're like well what the hell am I doing, I just nearly died, I've got this screaming, demanding thing that doesn't show me any love, everyone says to you 'oh you're going to love it straightaway' and you're like - that? And then you suddenly realise, oh I really, really, really love him and you wander round going I love my baby, I love my baby. And I don't know, it just sort of happened" (Sarah).

"I suppose it has been a gradual sort of thing and then really in a way sort of like things have sort of like changed you know ... suddenly sort of like, but then it really happened ... it really dawned on me that cor, dear ... You sort of trudge along and then like all of a sudden I thought cor, you know, this is really ..." (Lillian).

"I feel like a mother. Not in the way I used to view mothers...I suppose I used to view mothers as very organised, well like my own mother, sort of very organised, taking you to ballet, the person that took you to the ballet classes, took you to school, made sure that you had your wash or your bath or whatever...Whereas the way I feel like being a mother I suppose is just the cuddles...and the fun and just having a little person, a little friend. You know, she's like my little friend, but I am responsible for her as well, but there's less of a big gap and I think also that might be to do with the age difference because my mum was forty two when she had me whereas there's less of an age gap between us" (Rebecca).

"I do, but it's not...it's not always at the top of my mind that I am a mother" (Clare).

"Yes, I suppose I do really, just because the babies have changed and they do things like William will come and give me a cuddle...and you say 'give mummy a kiss', they'll come and kiss you...so I think it's just because they are doing more" (Wendy).

"But yes, I feel much more like a mother now than I did... I suppose I do feel like a mother...you're a person with a baby, you become a mother and you feel like a mother. And you call yourself mummy I suppose, don't you, as you're going about, you know you say, 'that's mummy', and 'don't drop mummy's bag again', then you call yourself mummy so I suppose that makes you ... But like now, I could almost forget that she's there and I do feel like me. But then when she's around I suppose I'm on duty again and you feel like a mother. No, I couldn't forget that I have her, but I could imagine life ... I could imagine life without her, I could imagine going outside for a walk and forgetting her. Not that I would of course! Yes, but you know, that would be a possibility" (Gillian).

This last extract encapsulates some of the themes running through the other accounts. One theme is that for most of the women, feeling like 'a mother' is a gradual process and one which even at nine months may not be perceived to have been achieved as Kathryn explains 'I don't know whether I do feel like a mother...that's what worries me'. If mothering is perceived as natural, then to not feel like a mother has implications for one's self. Kathryn voices her concerns that she is not a 'good mother' and that she might not have the 'right responses' and is clearly measuring herself against her perceptions of

how other 'good' mother are. Diana also doubts her own self as a mother 'am I really a mother? and I've felt that from the beginning'. Helen also notes that contrary to her expectations, she did not feel an 'instant mother', whilst Peggy is surprised by her enjoyment of 'the whole thing' and her 'maternal' self. Interestingly, Peggy begins to describe her experiences of being a mother as 'harder than...', but pulls back and admits confusion, 'I don't know, it's easier and harder'. The increasing responsiveness of their babies is noted by other mothers and is used to explain their sense of feeling like a mother.

The narratives produced in these final interviews around mothering as an identity can be seen as fluid and at times contradictory. Whilst Diana talks of her doubts 'is it really me?' she also confirms in the same extract that 'yes, I do feel like a mother, very mumsy'. Gillian also talks of being a 'person with a baby' and as a result feeling 'like a mother' and being 'on duty', but also being able to feel like 'me', an identity distinct from mother, and whilst she 'couldn't forget that I have her', she 'could imagine going outside for a walk and forgetting (to take) her'. Experiences then are made sense of and voiced in relation to other influences, for example, expectations and assumptions around 'good' mothering, memories of being mothered etc. The narratives which are produced can be seen to be multi layered and contradictory. Gillian talks of her different identities and the possibility that she could forget her baby but quickly asserts 'not that I would of course', clearly 'good' mothers would not do such a thing. In Kathryn's extract, a thread of personal narrative is discernible when she voices her worries around 'bonding enough' and 'right responses', she asserts that her 'self-image hasn't changed' as if this might be an explanation for why she doesn't feel like a mother. To admit to feeling that you have 'borrowed' your baby is a difficult revelation, it does not conform to publicly recognisable ways of describing experiences of motherhood.

What can and cannot be voiced around experiences of mothering then is clearly set within the context of other influences, and inextricably linked to sociocultural, 'racial', ethnic and structural positions. The experiences of the women in this study were narrated within the context of pervasive notions of what 'good' mothers were like, that is, took up all aspects of antenatal care, didn't need medical intervention at the birth, bonded with their child as well as doing the practical things required by mothering and present as competent social actors as mothers and coping. What is also apparent from the ways in which the women negotiate and make sense of their experiences is that the passing of time is an important factor in what can be voiced. But some things may never be voiced. An interesting interchange took place in one of the final postnatal interviews which touches on the limits of what can and cannot be said as a mother (or parent).

- Abigail: "I guess we're just lucky, he's a nice child. But then have you met anybody who's not liked their child?"
- Tina: "I know people that...there have certainly been a couple who've found it quite difficult to really fully feel even at 9 months that the baby is properly theirs and ..."
- Abigail: "But nobody surely criticises their child?"
- Tina: "No, no, no-one does, no, that is true"
- Abigail: "Because I think he's lovely, but I'm bound to"
- Tina: "No, that is right, no-one criticises...they might feel concern that they're not doing a good job necessarily or that things could be better or whatever, but no, the babies have all been ..."
- Abigail: "wonderful babies"
- Tina: "Well no, some have been little sods I think but..."
- Abigail: "But do parents admit that?"

Tina: "But no, and some have felt that...no, I mean no generally the babies have come out pretty well"

Abigail: "Yes, exactly, it's .."

Being a Mother.

By the time of the final postnatal interviews some perspective could be brought to bear on the shifts which had occurred as a result of becoming a mother. Whilst experiences had differed and the time taken to feel 'back to normal' had varied, giving birth to a child and coping had led to a reordering of priorities. Shifts had occurred in the ways in which the world was viewed and the women's own perceptions of themselves in that world, and by nine months many of the women felt they had regained some control, some order in their lives. A growth in confidence is also linked to a clear sense of achievement as the following extracts show,

"I feel so much more in control now and I think that's because my hormones seem to have gone back to normal...I'm how I used to be before I had Jessica now" (Rebecca).

"all in all it's just been a life changing experience...I don't ... I think I've got a much more positive self-image than I did before because although I sort of feel all these emotions about not feeling I'm doing anything properly, really ultimately you only have to look at your baby to know that you are. And you know I just feel sort of more confident, although I was never a wallflower, but I do feel a bit more confident about my ability. You feel like you've joined a club and that you suddenly know so much more than you did, and I don't know why. And I don't know, what else do I feel about myself? Well I suppose I feel quite pleased with myself a lot of the time" (Diana).

"there's times when I'd like to be able to turn round and tell them to stuff their job and there's more important things to life than you know, whatever the problem is...Yes, I feel more ... more sure of myself. You know it doesn't matter to me now if I don't go out ... if I go out of the house without make-up on or you know I look a mess because there's some people who get their figure back by working out and they will always wear make-up and I think, yes, I want to look nice, but it's not the end of the world. People can take me for what I am...I've achieved something fantastic with him. He's you know the most incredible thing ever. I don't need anybody else to ... to have a good ... high or low opinion of me. It doesn't bother me. I know what I've done and if someone thinks I'm fat well you know it's their problem" (Abigail).

"But now I have more of a ... I feel I have more balance, I mean it's affected me ... I think it's changed my outlook. It certainly has changed my kind of confidence ... I am probably more confident than I was before actually as a result of having ... because I sort of feel I've ... I've sort of done relatively well you know so I mean although it's really early days but sort of thing she's obviously thriving and ... and I sort of feel a bit more ... probably a bit more balanced rather than ... but I certainly kind of have the same sense of my own identity

... I mean probably ... I don't know really...which is one of the reasons why I wanted to do something outside the home, definitely, I felt I needed that space and time, well not really space because it's ... it's just filled with something else, but I need that time away ... away from her, some of the time, and I just ... so I think work has got a lot to do with it, but because I'm doing the two things now, it's probably kind of made me feel more ... in a sense it hasn't actually made me ... given me a split identity at all actually, it's just kind of made the whole thing a bit more whole, a bit more ... in a good way, I feel quite genuinely positive about it" (Philippa).

The women's growth in confidence and their abilities as mothers are linked to the development of their child, with comments such as 'she's obviously thriving' and 'you only have to look at your baby to know'. The enormity of creating another human being overrides other concerns, 'people can take me for what I am...I've achieved something fantastic with him'. These women, who have all returned to work, appear to have achieved a 'balance' in their lives. Kathryn also talks of feeling more positive about her self,

"Yes, I like myself better, and I think I feel that I...I remember saying this to you before, I feel I've got much, more to offer. And I don't worry nearly so much about myself, my identity" (Kathryn).

But this is within the context of real concerns about her mothering responses (see the participants' previous extracts above) and a sense of unhappiness about the 'routine' of her life, although she narrates this unhappiness within assurances of still 'coping' as the following extract shows,

"I feel I'm coping. I feel I'm on top of it, but I don't enjoy my life particularly. It's ... you know it's back to this rehearsal. It's ... I'm doing it because I've got to. I mean I remember bursting into tears last whenever it was Sunday with Christopher (husband) and I said look, it's the bloody routine, the whole ... I get up, I feed Rupert, I get myself ready, I make my sandwiches, I walk to work, I do my job, I come back at lunchtime, I walk the dog - I have to fit in a walk and seeing Rupert at lunchtime - I come back to work, I come home, I bath the baby, I cook supper - and I'm knackered!...Oh, it is shattering. And every bloody day is the same. It's a routine. And if only it was different" (Kathryn).

A further shift which had occurred in the participants' lives is also linked to their perception of themselves as mothers. In the early postnatal interviews several of the participants spoke of restricting their interactions in the public sphere because of a concern that they would not be seen as 'real' or 'proper'

mothers. In the following extracts taken from their final interviews, Sarah and Clare talk of their confidence in knowing their own child and coping in public settings,

"And I don't know, it just sort of happened. But ...like when we go to cafés or something it's like I need to ... you have to explain to your friends, I need to sit in the non-smoking area with a high-chair, with a baby room, with baby food, and it's like you're sat on the bus and he starts screaming half way through the bus ride, and I can sit there and let him scream because I know he's moaning because he's stuck on the bus, and it's not that he's in pain, and all my girlfriends go what's wrong with your baby ... I think it's just ... and you can see that everybody else on the bus is freaking out and you think, chill out everyone, it's just a baby, you know" (Sarah).

"For ages I was conscious of you know when he was crying and things, but I mean now he cries, you just sort of laugh ... laugh at him and ... and everyone knows ... and you think ... you go round Tesco's and like where a few years ago if I heard a baby screaming I'd think, oh what's wrong, now you ...just you know, dropped the toy, wants some food or something, you just think, oh well..." (Clare).

Reflection and Narrative Reconstruction.

The analysis of the narratives collected over the course of the three interviews revealed that telling stories of transition to motherhood is not unproblematic and that experiences are related, as has been seen, within the context of other influences. Experiences can be difficult to voice, especially where they do not appear to fit with previous expectations or to resonate with the perceived experiences of others. In the final interviews the women were again asked to reflect on their experiences of becoming a mother and for some this presented an opportunity to re order and reconstruct the narratives that they had produced in previous interviews. A developing confidence in their own abilities and the gradual transition to 'expert' around their own child's needs empowered them in reflecting and challenging aspects of what had gone before. They were able to position themselves differently in relation to those they had previously regarded as experts, the health professionals. The passing of time can be seen as a prerequisite for reflection, and distance also provides a sense of safety, the risk of revelation

is not perceived to be so great. Having experienced eight to nine months of mothering, difficult experiences can now be voiced, revelations made because they have been survived. In the early postnatal interviews many of the women produced narratives within the context of now being able to cope, things in the last week having got better, etc.. any difficulties had been resolved. Yet in these final interviews some women contest the stories they had previously constructed and wish to present a different, more honest (?) version.

In the following extracts Helen talks of her experiences of becoming a mother. The first extract is taken from her first postnatal interview in which she is asked to reflect on her antenatal preparation, she comments:

"The only thing that I ...I could possibly sort of criticise on now ...I wouldn't say it as a criticism, but what I was not prepared for at all (was) the emotional changes of when you come home and suddenly you're living this story life when you have the baby, and suddenly when you come home and after all the visitors have started to dwindle off and its just you that's left...and I would say that I hadn't really been prepared for those feelings of actually being out of control, *which I would say probably only the last week that I've actually got on top of it and I'm actually starting to feel a little bit more in control...*" (emphasis added)

In her final interview, Helen felt able to disclose retrospectively how she had been really feeling during those early weeks of becoming a mother,

"the emotions were so intense, I think in every way, that my life just turned upside down...I don't think that there is anything that anybody can do to actually prepare you for the change it's going to have in your life. I talk to people about it now because I think that *...you know it is difficult to talk when everybody is so wonderful that in fact you don't want to create any negative sort of impression* to you know people around you so you sort of go with the flow, but inside you're actually quite terrified, and yes, now I can talk to other people about it and they say 'gosh, but you, you would never have known - you know you had this real sort of positive, enthusiastic, unflappable way about you at that time', and maybe I did, but I know now *and I can express myself as to how I was sort of really feeling...*I know that a couple of questions you asked me sort of first I was bordering on bursting into tears you know, *but I mean obviously I contained myself but you know I wouldn't let this other side sort of...*Because I don't think I ...you know I didn't express it to anybody. You know not my health visitor, not ...not Stephen (husband), you know my sister and my mum you know have been great sources of support but they have been so capable" (emphasis added)

The difficulties of giving an account which does not resonate with the expectations of those around you, or your own expectations, are all too clear in this extract. The overriding need to 'contain' personal experiences - to avoid giving any negative impressions - and give a coherent narrative of being a 'good' mother appears to be paramount especially if those close to you have coped well and been seen to be 'so capable'. And this may not only be the case for new mothers, Helen goes on to describe the difficulties her husband has had in voicing his experiences:

"...it's a very trying, difficult time and I know that he had emotions *which he again didn't express then, but he does express now*, because he didn't want to make out to anyone that this...this lovely...rosy sort of glowing impression of *how it's supposed to be* in fact maybe wasn't quite as rosy, the reality of it when you get home.." (emphasis added)

The importance of presenting an acceptable and publicly recognisable account of new parenting is apparent in this extract and the disclosure of other feelings - even to each other - is perceived as risky. It is only retrospectively that such experiences can be voiced. Interestingly, Helen used the end of study questionnaire to again confirm the difficulties she had in voicing her actual experiences,

In the second interview it was one of the first times anyone had taken so much time in concentrating on my emotional state (even more than the health visitor) - but I now realise that I was not being 100% honest with my answers and was too eager to attempt to create a feeling of control, relaxation and total happiness and contentment. (In fact I was feeling quite disorientated and out of control). (Helen).

Kathryn began her final interview in the following way,

"And I think actually ... I don't think ... *I was pretending that I was coping better than I was. I must ... I must admit that looking back on that interview I thought I hadn't done terribly well.* You know I thought ... sort of thought oh I wished you hadn't interviewed me then because I don't know, perhaps I'd just had a bad day or I don't know, I just remember ... Well I always come across ... more in control than I actually am. I'm a real sort of swan paddling below the surface....I think we all ... I think all new mothers feel that they've got to do terribly well. I mean you know everyone says to me in a way I don't want it to change my life, I don't want people to think that I'm not coping or I don't want ... you know, life's got to go on, that's ... that's the general feeling. *And why should we all feel that?*" (emphasis added).

Having begun the interview in this way Kathryn then goes on to voice her worries and concerns over her mothering abilities which continue to trouble her. Having challenged the need to contain difficulties 'and why should we all feel that?', Kathryn proceeds to reveal personal layers of narrative which might have remained unvoiced. The narrative she presents is complex and contradictory as noted in the extracts which appear in other sections of this chapter. Her use of words such as 'which is an awful thing to say maybe?', 'do you think all mothers feel that?', show her seeking reassurance and possibly permission to voice what she feels are not 'normal' ways of talking about being a mother (See Chapter 8).

A comparison of Sarah's postnatal interviews also reveals interesting shifts in the ways in which experiences are narrated. In her earlier postnatal interview Sarah had spoken about her feelings on becoming a mother. Her birth had proceeded rapidly in hospital without any need for pain relief and she again reiterated her belief in the process of birth being coped with by adopting a positive 'state of mind',

"and having him was fine, I didn't have any drugs...to be honest I think it's all a state of mind. I think some people if they're encouraged to know that they are ... they're a human being and we've been doing it for thousands of years, then they can handle it and I've sort ... people I know are like that, that's their mentality, but there again if you're told ooh, ooh it's going to be really horrific, you better take everything available, then you will because you haven't been shown that there is another path to take you know. And I mean I'm not knocking people that take epidurals and all that kind of stuff because I understand that it most probably ... if you panic then hey, god it must be horrendous. I panicked twice and I realised how much more horrendous the experience was when I panicked. *And then I thought to myself wow!, aren't I amazing.* You can control everything that's happening to you. You know breathing you can actually control the pain and I'd anticipated it being absolutely horrific, so it wasn't ... it was worse than I thought but it wasn't as bad as I thought...I mean I think I was incredibly fortunate, you know. And I think it's maybe just because ... maybe my upbringing has ... has told me that, that you are in charge of yourself, and that you don't need drugs and this, that and the other, you can do it all yourself. So I mean that's ... I was lucky, I knew I could do it, and there again I knew I could fall back on the drugs because it would be awful saying to people I'm having no drugs and then you get there and you think god I need it" (Sarah).

Sarah's comments at the end of this interview were,

"Yes, but I am very fortunate and I'm having a very good time. It wasn't good at first, *but now it's brilliant*. We're enjoying ourselves" (Sarah).

In her final interview Sarah reflects on the previous months and talks of having experienced a period of what she now describes as prolonged 'shock' since the birth of her baby,

"I actually feel that I was ... maybe not post-natally depressed, maybe in shock definitely, I feel I was in shock up to about a month ago because I've only just started tasting food again...And my mum said to me oh that's a sign of shock ... is that you stop tasting things and smelling things. I've only started smelling things again since having him, it's really weird. But I don't think it was depression, I actually think it was shock, and change of the ... you know. But no, I just think it's the shock of the whole ... the whole sort of ... I don't know, .. no, they don't sort of tell you these ... not that they tell you, it's just ...*the reality of it all smacks you in the face* doesn't it, and you either ... you either go one way in that you just handle responsibility over to other people and you then lose your child, because you can do that, or you take it all in your stride *and do it the right way*, which you should be doing, which you are capable of doing. But it's like I say, my cousin you know, she's having a really bad time, and the only way she can do ... I mean I believe that she is taking it to the extreme that she is ... she's got a chemical ... a chemical imbalance in her brain definitely, she's ill, but she's got a good man. You know like my cousin a social worker and he's a really good man, and .. She is in a position to say take the baby, I can't handle it, which I would love to do, but I'm not in a position. I can't hand him to someone and say take him, and me run away, because ... so I just feel it's the shock of giving birth. *Oh my god, it's the closest I've ever been to death, Jesus!*" (emphasis added) (Sarah).

By juxtaposing these extracts, the contradictions between and within accounts are highlighted. The difficulty of voicing negative experiences is also apparent and particular time frames are also used to place distance between the lived experience and narrating that experience. In the first extracts Sarah talks of 'it wasn't good at *first*, but now it's brilliant'. In the final extracts Sarah again places her experiences within a time frame, the implication being that *now* everything is fine, 'I feel I was in shock *up to about a month ago*'. The intricacies of narratives are also apparent in this final extract. Sarah says that 'the reality of it all smacks you in the face doesn't it?' apparently acknowledging that the lived experience, 'the reality' of being a mother differs in some ways from expectations. Here she appears to be challenging the dominant ideologies which surround motherhood, but

she then goes on to talk about there being a 'right way' to do mothering which seems to support a particular notion of motherhood. Different ways of narrating the same event, but after the passage of several months, are also demonstrated in the extracts from Sarah's early postnatal description of giving birth and her later description of the same event. In many ways they do not appear to be descriptions of the same event. In the first Sarah says 'and I thought to myself, wow! aren't I amazing' and, in contrast, in her final interview she notes 'so I just feel it's the shock of giving birth. Oh my god, it's the closest I've ever been to death, Jesus!'. The passage of time then enables a reordering of experiences and events and shifting perspectives can help to bring new meanings to lived experiences. Narratives then can be seen to be continually revised, reconstructed and presented.

The ways in which time is used to organise experiences into coherent narratives is also demonstrated in the extract from Philippa's final interview below,

"Well I remember ... I sort of remember things in terms of like watersheds quite a lot and I think that 3 months was the first time ... because *I remember feeling a bit more human again at that point*. So from sort of 6 weeks to 3 months I just probably much rather saying but getting a bit kind of ... a little bit easier and getting you know to grips. *I think also my expectations probably changed*, I thought I don't really mind sitting breast feeding the whole time you know and things, but by the time she got to three months it kind of ... *I found I was feeling a bit more like my old self again*, I was *getting parts of my life back*, I wasn't feeding 24 hours a day and sleep ... getting more sleep and you know all those things. And then I mean after that I remember sort of 6 months being ... well between 4 and 6 months things just getting a lot more interesting and sort of *thinking this is more like what it's about* if you know what I mean, and I just ... she was much more responsive, I mean once she sort of started smiling and ... god, all sorts of things, I can't remember!...I really can't remember exactly when anything happened. It seems very kind of murky" (emphasis added).

Philippa organises her narrative around what she calls 'watersheds', times at which shifts were discernible, for example 'I remember feeling a bit more human again at that point' and later, 'I found I was feeling a bit more like my old self again, I was getting parts of my life back' and 'thinking this is more like what it's about'. Her narrative then documents a journey through early

motherhood in which her expectations had to change to accommodate what she was experiencing. An extract from her earlier postnatal interview provides a much more immediate account of Philippa trying to make sense of the early weeks of being a mother

"I mean in terms of my life changing ... I feel both ... I'm kind of enjoying what's happening now and I'm a bit kind of frustrated by the you know day after day on my ... a bit on my own, I mean even though I do see people it's kind of for an hour or so or whatever, and I do ... I sort of think, gosh you know, this is major decision, a major change, you know I just can't ... I can't turn the clock back or anything now. I mean ... and I felt that very much over the first ... that feeling's getting less and I'm sort of now ... I'm getting more to the stage where I couldn't imagine life without her and I'm enjoying her a lot more, *but that's been kind of gradual. But there's a little bit of thinking, gosh, what ... you know what have I done?* Yes. So a bit of sort of ... a few negative feelings and ... *But you know, on the other hand I really ... you know I'm sort of enjoying her* and I sort of think you know in a way this is more what life's about than working or whatever you know, which is what I had before. You know, some aspects of my life before seem quite sort of empty comparatively you know ... life without children I think, and I think that's kind of ... that's coming to the fore more and more, *it's just more of a gradual adjustment* rather than something that I felt immediately very strongly. And I sort of ... I do go back to work and I sort of think I've no desire really to be here at all you know, I don't ... especially with nice hot days you know, yes. You know, I sort of think it's fairly ... some of it's fairly petty and ... you know, it's certainly not a hugely worthwhile job in a way, so it just seems ... this sort of seems part of a bigger part of life you know..." (emphasis added)

The narrative Philippa produces at this point can be seen to veer between presenting as a competent and coping mother and trying to voice her actual experiences. Negative aspects are tentatively voiced 'but there's a little bit of thinking, gosh, what...you know what have I done?', but always within the context of returning to more publicly acceptable ways of describing becoming a mother, 'but you know, on the other hand I really...you know I'm sort of enjoying her'. The gradual and individual nature of transition is also emphasised. At the end of her final interview, Philippa reflects on her experiences of transition,

"I surprised myself by how badly I coped in the first few weeks actually because I kind of ... because I've always ... I'm the kind of person that tends to cope reasonably well. I'm quite ... I know that I'm quite balanced and I'm fairly laid back and I'm fairly competent and things, so I expected myself to have ... *I had a kind of vision of myself* with children which was that it was all kind of ... I mean not completely brilliant the whole time but I sort of thought ... I thought it would be fine, I thought I'd be OK, so I'm not really surprised by that, but I was surprised by ... because she just cried quite a lot in the first few weeks that I was

surprised by that, I just thought, oh my god, *I'm not sure that this was quite in my kind of vision* of things which hadn't like a very kind of demanding, wingey, difficult baby which is how she was" (emphasis added)

Her 'vision' of herself as a mother, her expectations were not initially met and the difficulties she experienced were not part of her vision. Other mothers accounts also revealed a reordering of experiences. Reflecting on their first eight to nine months of mothering enabled the participants to make sense of their, sometimes difficult, experiences. A growing confidence, grounded in ontological experience enabled them to challenge aspects of what had gone before.

Concluding Discussion:

The 'fluid, partial and complex' properties of narratives are apparent from the extracts included in this Chapter (Goodson, 1992). In her study of changes in self - identity in the transition to motherhood, Bailey argues that 'motherhood is an opportunity for renewed narrative movement par excellence' (1999:351). Yet whilst transition to motherhood can be seen to provide new material from which narratives can be constructed, the enterprise is not as straight forward as suggested¹. The participants in this study could be seen to struggle, at times, to produce what they perceived to be acceptable narratives of being a mother. The difficulties of voicing to others unhappy or unanticipated experiences around early mothering has been noted in other research (Paradice, 1996). In her study of women during the postnatal period, Paradice found that "the majority were totally unable to tell their partners, their mothers or even other women (because) society does not allow these feelings" (Paradice cited in Motluk, 1996). However, in these final

¹Bailey's article 'Refracted Selves? A study of changes in self-identity in the transition to motherhood' provides interesting data on women interviewed in the later stages of first time pregnancy. However, I would argue that at this stage in their transition, women are still *anticipating* motherhood, they are not yet mothers and this, I think, weakens some of Bailey's arguments.

interviews a shift in the ways in which narratives are constructed is discernible. Whilst earlier interviews had produced narratives which functioned to convey a sense of 'appropriate' antenatal preparation, and 'coping' with early mothering, in the final interviews the narratives are not so constrained, although at times remain tentative. A shift in how the women perceive their own mothering abilities (in effect they have become the experts) signals a shift in the types of narratives they feel able to produce. Confidence grounded in experience leads to threads of resistance, what Somers calls 'counter narratives' (1994) becoming more apparent in some accounts, for example professional advice can be challenged and/or ignored. More importantly previous difficult experiences can be voiced and narratives revised.

The passage of time then, and a shift in perception of self as a coping mother enables reflexivity and the reordering of events. As Frank has noted, "the chaos that can be told in story is already taking place at a distance and is being reflected on retrospectively" (1995:98). The development of a research relationship will also have enabled some women to talk more freely. Whilst the elapse of time and distance from an event may be prerequisites for reflection, the participants were also more familiar with me, and the process of being interviewed, by the time of their final interview (see Chapter 8). In addition, a return to work outside the home and the resulting movement in and out of different 'worlds' had involved shifts in priorities and alternative perspectives to be adopted. The influences and contexts within which participants (re)constructed their narratives then can be seen to have shifted by the time of the final interviews. As Stanley and Wise (1990) note, 'reality is much more complex and multi-dimensional than we ordinarily suppose it to be, and it is contradictory' (1990:64) and the women's narratives can be seen to engage with, and at times struggle with, these complexities and

contradictions. The resulting multi-layered narratives are differently constructed by the time of the final interviews: a growing confidence in their own abilities as mothers leads to a reordering of knowledges, with the privilegedging of those grounded in experience. So whilst layers of professional, private and (sometimes) personal narratives can be discerned throughout transition to motherhood, it is apparent that the experience of being a mother can lead to a privileging, eight to nine months postnatally, of private and personal accounts.

Chapter Seven

A Lapsed Narrative?

Introduction.

In research involving the collection of qualitative data, decisions must be made in terms of how to manage and organise the data. Whilst analysis of the data will usually reveal patterns and themes which then shape its presentation, further decisions are usually required. A decision was taken in this study to organise the data around particular periods; antenatal, early postnatal and late postnatal. And whilst the effect of this has been to present accounts along a continuum, in some ways mirroring transition, it has also led to participants' narratives being 'truncated' and clustered around particular periods. In effect the need to adopt a reductionist approach in terms of data management leads to snap shots of data being used. The focus of this chapter therefore will be confined to one participant's account of becoming a mother. The participant, Linda, has been chosen because her experiences of becoming a mother have been difficult and, for a period, apparently too difficult to narrate. Linda opted out of the early postnatal interview but chose to re-enter the study for the final interview when her baby son was nine months old.

In his book on illness narratives, Frank (1995) 'presents ill people as wounded storytellers' and identifies three narrative types that can be discerned in stories of illness; the restitution narrative, the chaos narrative and the quest narrative. It is the notion of a chaos narrative that is of particular interest here. For as Frank argues, "those who are truly *living* the chaos cannot tell in words. To turn the chaos into a verbal story is to have some reflexive grasp" (1995:98). Linda's experiences of becoming a mother and the depression that engulfed her during the early postnatal months left her unable to narrate the chaos she was experiencing and she opted out of the study. The ways in which Linda negotiates and narrates her anticipation of

motherhood will be explored in relation to her final interview where she places herself as a survivor. Her strategic use of different layers of narrative will also be examined.

Anticipating Becoming a Mother.

The narrative constructed in Linda's antenatal interview is peppered with references to 'common sense' and her being 'laid back', together with the 'shock' of the changes which can occur around pregnancy and feelings of 'loss of control'. The contradictions then are marked. Negative feelings are revealed within the context of always reverting to more publicly acceptable ways of negotiating and narrating pregnancy. In the following extract Linda, having described her pregnancy as 'planned', describes coming to terms with pregnancy and redundancy,

"The first three months I didn't enjoy, I didn't enjoy at all. I mean I don't think the whole pregnancy throughout has been very enjoyable, but the first three months - I wasn't sick or anything like that, it was just like...I think it was because I was made redundant, and then I found out I was pregnant, that I think all those kind of things got on top of me, so I was not happy about the whole situation, even though I wanted to be pregnant, it was...it was just ...I think it's the fact that something else has taken over your body, the fact that you have to give up things that are probably not so important, but you still have to, you know, change your whole way of life really to carry a child. I used to smoke and as soon as... I always vowed that as soon as I knew I was pregnant - I didn't smoke a lot, it was just an occasional thing - as soon as I knew I was pregnant, that was it. You give up smoking, you give up drinking, you give up the yoghurts, the ...all the things that they tell you to give up...and I'm thinking this is not fair, you know. But now, because of you're feeling the baby and you get to sort of understand it a bit more - well, you can tell because...so much bigger, that yes, I do...I'm looking forward to having the baby"

It is interesting to note the ways in which narrative is used to present a particular type of self, Linda talks of giving up smoking because she is pregnant, but asserts that 'I didn't smoke a lot'. She rationalises her negative feelings around her pregnancy in terms of her redundancy and her gradual coming to terms with being pregnant as her body grows and changes. She also confirms that she is engaging with expert advice and changing her lifestyle accordingly, 'all the things *they* tell you to give up' and ends with asserting her positive anticipation of becoming a mother, 'I'm looking forward to having the baby'.

Like most of the other mothers in the study, Linda talks of having an ultrasound scan and finding this reassuring. This event was also seen to mark the beginning of her husband's involvement and interest in the pregnancy,

"That was at twenty weeks (the scan)...I suppose I didn't actually feel that pregnant until you actually see that baby on the scan, then, yes, it becomes more real. And I think the most interesting part of it was actually not seeing the baby moving, but to see my husband's reaction to it all. Because we were sort of very casual and, you know weren't really taking it in, and he was...you could tell that, you know this was real, it was exciting, and plus he wanted to know the sex of the child...it's a little boy. But I think until ...because my body's actually changed so dramatically - my stomachs' got bigger, but my backside's quite ...god, what do I look like!"

Linda continually refers to the bodily changes that have occurred since becoming pregnant. She feels that she should have been better prepared and reflects on the sex education she received at school,

"...but they never told you about pregnancy, they never told you that your whole body would actually change, that your hormones would change, that you'd cry occasionally for no reason whatever, that your stomach would stretch to its limit. And they never explain those things and I think it is a shock for anyone. Some people really enjoy it, but because I was so thin and I enjoyed being thin, to actually be to me big, very big, it's like a bit of a shock"

Coming to terms with the effects of pregnancy are again made sense of within the context of being made redundant,

"I didn't know what to expect. And I'd not really thought about it. I think I've been very selfish in the fact that I've worked since the day I left school, the last job I actually had I was an admin manager, so I was actually in control of other people, I had an income and I enjoyed that income because that was guaranteed money and I could do as I pleased and to be made redundant and everything stop is a bit of a shock to the system anyway, isn't it?"

Redundancy has led to Linda's isolation from a particular world, a world in which she had economic freedom and was in control, not just of her self, but 'in control of other people'. The changes which pregnancy had led to, had propelled her in to a different world where she felt she could no longer exercise control around her 'whole body', or be her 'normal self',

"I just feel that it's something that actually takes over your whole body, something which makes you feel extremely large and sort of...and that's been a surprise...I just hadn't thought about it. I hadn't really sort of you know, I've seen other people and you see how it affects them, and in some people I thought how nice it looked, in others I thought 'goodness me' you know. But to me it's a 'goodness me'. You know, it was like 'ouch'. But hopefully it will go away and I'll get back to my normal self. I feel unattractive. I feel just lumpy and...fortunately I've always been slim...I mean

I've been between eight and eight and a half (stones) and that's how I've wanted to be. And I couldn't imagine myself being fat, I don't like fat, I don't think there's any reason unless you've got a serious problem to be fat. I'm not saying I'm prejudice against big people...I just don't want to be big. I'm now sort of ten stone two I think it is, and that is ginormous, it really is...it's like, you know, the shock of standing on the scales and thinking 'really!' how can I get that big? And then I convince myself that it's all baby"

However her husband, she says, has been very supportive of her changing body shape,

"Well, I've actually said to him I'm so unattractive and he's said to me, you know, you're not unattractive, you're pregnant and you're going to be big. Also I think it's because he doesn't like ...he doesn't find big people attractive and he's always said that, so I've perhaps got it in my head I'm big, I'm unattractive. But because I've said that to him, he's reassured me, he's said, you know, that's not true because you're not excessively fat, eating Mars bars continuously and trying to put on weight, you're pregnant and it's fine".

Reassurance from her husband, that her changed body shape is acceptable because it is a result of pregnancy and not self inflicted (through 'eating Mars bars continuously') is sought by Linda. Control over her body shape has clearly been exercised by Linda in the past and the perceived loss of control, around something which is closely bound up with presentation of self, is experienced as problematic. When asked about what she had least enjoyed about being pregnant, Linda continues this theme,

"The thing about something else actually taking over your body...out of control. Because I suppose I got pregnant quite late in my life ...I'm twenty nine now. And most of my friends have actually sort of...they've got children and they're three and five years old, you know, and they've got another one. Because I've had that independence, that way of life, that I could just please myself as and when, then you become pregnant, your whole body's taken over, you feel very sensitive to things that you could just sit down and cry sometimes, and the fact of becoming so large and...not obscene but I never knew that...I suppose I shouldn't say this, but I never knew that your backside could actually increase double the size just through being pregnant. That's happened to mine....Yes, I'm reallyI know that there's going to be a bundle of joy at the end of the day and that's what I'm looking for, but I wouldn't go straight into being pregnant again. I think I'll have to be convinced that you know...I feel that from being the person in charge, work-wise, to the person that is being taken over by something else or someone else, is quite a lot to take in"

In this extract, Linda acknowledges the existence of public and lay definitions around what are perceived to be appropriate periods in a life when pregnancy is anticipated / expected, and that her pregnancy does not 'fit' with these. Her experiences of being pregnant have not been as she had anticipated and she looks to her age and the 'independence' of her previous way of life to try to make sense

of the changes she is experiencing. She seems aware that the way in which she is describing pregnancy does not resonate with public narratives and is tentative in voicing her personal experiences which don't fit, 'I suppose I shouldn't say this'. Yet having risked disclosure, she quickly returns to the 'acceptable' language of public and lay knowledge's and asserts that she knows 'that's there's going to be a bundle of joy at the end'. Linda also talks of her friends reactions to her and her pregnancy,

"...the whole conversation revolving round, you know, ooh, you're carrying the baby, have you felt the baby, you know when the baby comes we'll do this, that and the other, baby, baby, baby, and I think, well hasn't anybody else got anything to say to me? Can't we talk about the weather for a change? And I think it's because people do feel that you want to hear that and it's like they're ...I don't know...it feels like they're just sort of keeping everything sweet, keeping ...you know...I mean I probably did it to other people, but you know it's 'when the baby's born, I'll baby-sit', not 'when the baby's born we'll go down the pub and you know we'll have a drink, or you know we'll go out somewhere. It's as if your whole identity changes from here on. Bye bye the old Linda then, hello mummy, and that's not going to change everything. And I won't allow it to. I'm not going to be ...I hope that I won't be the kind of person that only goes to Bournemouth for a holiday because of...I mean I still will go abroad and I still enjoy what I've always enjoyed. Hopefully that's my intentions but yet I don't know until this baby comes out what way it will affect me"

This extract is interesting because Linda both stridently *and* tentatively voices her thoughts around becoming a mother. Her perception of friends 'keeping everything sweet' hints at something more worrying behind the façade of their baby-focused conversations. Whilst she already feels that changes have occurred in her friends' perceptions of her as a mother-to-be 'it's as if your whole identity changes from here on', she also attempts to assert control 'and I won't allow it'. Linda can be seen to be struggling to produce a narrative of preparation for motherhood which can contain competing and, at times, contradictory, feelings. So whilst she is unhappy about her changing body shape, she talks about support from her husband and uses publicly recognisable expressions such as 'there's going to be a bundle of joy at the end' and 'I'm looking forward to having the baby', and 'there's something special at the end'.

Whilst it is Linda who is physically going through the pregnancy, she repeatedly refers to the support she is receiving from her husband,

"...he's been so supportive because I know people that husbands or boyfriends that aren't so supportive and I don't think it's nice to go through it on your own....Because you do feel sometimes that you just want to cry for no reason and he's been so supportive that if I have felt that way, he'd comfort me and say, you know, I don't know what you're going through but I know why so, you know let's just sort of cuddle and ..."

Linda also anticipates their lives together once their baby is born,

"I don't really want it to change my relationship with Philip because we can cuddle when we want, we can sit and relax when we want. We don't have to think of anything else but ourselves. And again that is a very selfish way of looking at it. But I want to ensure that the three of us are together. It's not just me and baby and Philip being the father that goes to work and comes home and you know doesn't really have a part in it. And I don't think he would allow it anyway because you know he's so looking forward to this. But I want it to become a very special thing"

Anticipating the Birth.

In the same way as the other participants in the study, Linda had attended parentcraft classes and had contemplated the different forms of pain relief available for use during labour,

"I want to use a TENS unit, I want to try that. Until I know what this pain really is, then no, I haven't actually decided ...I don't think I want an epidural, I'd rather go without...because they say, some people say it causes back problems, others say it doesn't. Some people say that, you know, you have to have...oh, what are those...to go to the toilet?...Catheter, that's it. Some people say you have to have them. And I don't really fancy sort of laying with one of those by the side of me. You know, all those kind of things put me off. So, I'd rather try for as near natural as I can possibly go. And if it hurts that much then it's a caesarian...!"

Linda had also thought about the time *beyond* the birth to the practicalities of life at home with the baby. This may be related to her redundancy and the unanticipated time she has spent at home during the months of her pregnancy. She talks of her hopes that the parentcraft classes she has recently started attending will provide her with the advice she thinks she needs,

"because again these parentcraft classes...will actually hopefully show me how to look after the baby, because all hospitals or the (local hospital), they want you in and they want you to give birth, they want you to have the baby, they want you out. There's no - not that I like hospitals and I don't want to stay in too long - but I don't think they actually give you the time to adjust and to be confident within yourself. They send you home and OK you get the visit from the midwife and the health visitor, but to be put in your own home and being told that's it ...I think that's you know sort of quite concerning. And I think the only way you're going to actually learn is through going through it yourself and trial and error. If you put the nappy on the wrong way round then you'll

know because it won't work....you've just got to do it, haven't you...I think there will be people there for me, yes, and I think Philip and I will actually work things out together and just get on with it...Well you make it together, so ..."

Linda can be seen to be contemplating life at home with her baby, rationalising that health professionals will only 'visit' and that she will have to 'learn' the practical aspects of mothering through 'trial and error'. Interestingly, she talks of the need to 'be confident within yourself' and does not anticipate this coming naturally. Whilst this is of concern, Linda is able to find comfort in her belief that her husband will continue to be supportive, that they 'will actually work things out together' because, as she says, 'you make it together'.

The narrative Linda produces to describe her experiences around pregnancy is complex. Different layers of narrative are discernible and Linda can be seen to, at times struggle, to tell a certain story in a certain way. She presents herself as a successful actor in the world of work, as someone who has had control not only in her own life but over the working lives of others. Agency has been exercised and experienced within the context of economic 'independence', 'because I've had that independence, that way of life, that I could just please myself as and when'. Presentation of self has been inextricably linked to success in the workplace and the rewards from this, but pregnancy has involved unexpected changes to Linda's 'whole body' leading to a shift in perception of self 'hopefully it will go away and I'll get back to my normal self. I feel unattractive'. But a recurrent theme running through Linda's narrative is that her husband is supportive, helping her to place her experiences into some sort of perspective and she anticipates that this support will continue once the baby is born.

The Early Postnatal Period.

During the antenatal interview I outlined my research to all the participants and asked them if they would be happy to be contacted following the birth of their baby to arrange a further interview. Like all the participants, Linda agreed to this.

However when I contacted her to arrange a convenient time to meet for the first postnatal interview she was not sure about being interviewed. She explained that she had been diagnosed as having postnatal depression and that her husband and health visitor felt that she should not be interviewed. The lengthy telephone conversations with me suggested that she really did want someone to talk to. Eventually after several telephone calls (see notes from my Fieldwork diary - Appendix 9) contact was lost. After discussions with my supervisor I decided to write to Linda and request that she contact me if she wanted to re-enter the study for the final interview. I was surprised, and pleased, when she did contact me once her child had reached nine months of age.

Late Postnatal Interview

The final interview took place in Linda's home. I returned the tape of our first interview on this occasion and she seemed relieved to have it in her possession. Having at first asked that this interview not be tape recorded, Linda changed her mind (when I had to ask her to repeat a sentence I hadn't managed to write down) and gave permission for the tape recorder to be used. Before the tape recorder was turned on she had set the scene for the interview with the following comments,

"I have been to hell and back"

"I feel cheated of the months Nathan has been growing up"

"I never knew bringing a baby into the world could upset your life ...really"

A look at the transcript of the tape recorded interview also reveals my own lengthy contributions, possibly trying to provide reassurance as difficult experiences were voiced? Linda's child is now nine months old and she has survived, she is now able to reflect and narrate the 'chaos' of the preceding months she has lived through.

Linda begins by looking back at the preparation she undertook during the antenatal period,

"... when it came to the parentcraft I found her (health visitor) absolutely hopeless. I found that she put well I suppose a downer on everything. You know, like, oh god, you breastfeed and ... it was all sort of traumatised...And I wasn't happy with it at all and nor was my husband...No. I don't think anything can prepare you for being a mother. No one can put you in a category and say this is how it's going to be. It's different for everyone".

The birth was 'normal' according to the midwives perception of the event, but nine months after the experience Linda can recall it vividly and questions the definition of 'normal',

"I can remember it very well thank you. The birth I felt was horrendous, I really did. I think because of Philip I don't know ... we sort of ... on the birth of Nathan it was like we split. It was like the bond had gone between us and I could see on the expression of his face...Literally at the birth...ours has changed so much. And I wasn't prepared for that... I think it is because everybody thinks that mum and dad are ... the mummy and daddy are just going to be a bonding family and everything's going to be perfect tonight. But it wasn't, it just wasn't...we're still working at it....Oh, I won't be having another one"

"... a natural labour they said and I was really doing very well, but I suppose they've got that on tape, to say it to every mother that gives birth - 'you're doing really well' - even though you're probably not. Polite"

"Yes, I mean I had a normal birth, if you can say normal. And really it wasn't as bad ... I don't know, it wasn't as bad as I thought it was going to be but it was bad enough, you know. No-one can prepare you for that pain. And people who say that you forget the pain, I don't believe them, I really don't believe them... But you know, they say to you, you know, oh lovely you've got a little boy. And then it's like now I've got to stitch you up. Take your gas and air and breathe you know heavily. And I thought, oh, what do they mean? And that was so painful. The stitches were ... my god ... so uncomfortable. And the men ... I mean it's obvious that they can't appreciate what you're going through but they just do not understand that it is so uncomfortable, it's so draining, it's so stressful, and they think, you know, why have you changed? And you can't help it, can you".

"Yes, but I don't know. Again I suppose I didn't expect it to be so different. I just thought, and it was wrong of me thinking that, but I just thought that having the baby or having Nathan would mean we'd bond a lot more...You would be a family. And what has actually happened is we've like become friends".

"Because it (bonding) wasn't there when he was tiny and I felt that I was sort of left to deal with it all, and I was left to deal with it all. And I just wanted help, I wanted even just a cuddle, even just a response would have been nice, but it felt very empty".

The experiences Linda has lived through have led her to reconsider her own perceptions and challenge assumptions which surround 'family', that 'mummy and

daddy are just going to be a bonding family and everything's going to be perfect'. Having a baby then does not necessarily cement relationships or lead to 'natural' bonding. Indeed the experience can have the opposite effect, leading to the fragmentation of relationships. Linda makes sense of the changed relationship in terms of her husband's presence at the birth 'on the birth of Nathan it was like we split' and his continued failure to be able to understand her experiences of mothering 'it's so draining, it's so stressful, and they think, you know, why have you changed?' Ironically, Linda commented in her antenatal interview that 'you make it together' and that they would 'actually work things out together', sadly this had not been realised. But support has been provided by her parents,

"My parents have been absolutely brilliant. Without them I think I'd have cracked, I really do. I mean I'd have preferred that it would have been my husband, but he was dealing with it in his way and I was dealing with mine, and you know, we weren't dealing with it properly I suppose ...We were definitely working in different directions. So yes, I spent many a weekend there, haven't we Nathan?"

Difficult experiences of full-time mothering lead Linda to reflect on the world of work and the different opportunities that it offered in contrast to the 'boring', and all encompassing, dimensions of mothering,

"I miss work, I miss ... not work, not my job, but I miss the brain ticking, the conversation...Because you don't have that contact anymore and the contact that you do have ... I mean, I've got a really nice friend who lives in (town) and you know she's back at work or whatever and we don't talk about nappies, the price of baby food and boring things like that, because that does bore me, but you speak to other people and it's like, and how's your baby doing and my baby is doing this and blah blah blah, and yes, I don't mind listening to it but after a while you want another conversation".

"Yes, I would like to go back to work, just part-time, and you know if I don't like it, then I've got nothing to lose. But, yes, I'd like to venture out again, dress up in a suit, make an effort and you know, speak to other people, yes... I never thought I'd be carrying this (baby on hip) all the time. My briefcase wasn't heavy at all in comparison to a baby but that was heavy enough. And you can put the briefcase down, that's the thing can't you. Just leave it".

Linda's desire for 'contact', 'another conversation', to have a reason to 'venture out again', to 'speak to other people' set her experiences of being a mother in context. The world of work is perceived to offer different, more interesting opportunities, the assurances of a world she once inhabited. It is also a world which has clear

boundaries. Mothering in contrast has been a depressing and isolating experience as the following extracts shows,

Tina: "So when ... when we spoke on the phone you said that you'd filled out an A4 form [*Edinburgh postnatal depression questionnaire*] and been labelled or diagnosed as having post-natal depression".

Linda: "Yes".

Tina: "And do you think you have had that?"

Linda: "No. Me and my ... myself and my health visitor have actually spoken about it and she's said to me it's not post-natal depression. What you're going through is totally different. It's depression but it's through other reasons, other circumstances. She said if things were right in other aspects, you'd be fine. And I would have been and I think I'd have dealt with it in a totally different way, but I just feel that I've been weakened and weakened and weakened to the state where I do get very tearful, I do get sort of very down, and I suppose I don't really know anybody in the area because I've always worked and so you don't want to see people coming round every 5 minutes when you're working because you're so tired when you get home that it's like have my tea, go to bed kind of thing".

Whether the depression Linda has experienced, is experiencing, is 'postnatal depression' or otherwise, the isolation and unhappiness she has felt since the birth of her baby are palpable. Coping with the demands of mothering has led to altered patterns of behaviour, some of which have led to greater isolation. For example relationships with friends have changed,

"Um, really I don't see them very much anymore. I mean I used to be able to sort of as you know just get in the car, whizz off to wherever and not think of the time. Now you're sort of time, time, time, you know, he's due a feed at four, you know I can't go out after five because he's due to go to ... have a bath and go to bed or whatever. It's all time limitations".

"Well, but the thing ... like I've said I've never really put Nathan into a pattern because I've been going to my parents, I've been upset myself, so Nathan has never been put down at 8 o'clock and said this is your bedtime. So I think partly it is something to do with me, it's my fault".

"Well you have no time to yourself. I mean they go to sleep at round about sort of 8 o'clock because they're tired, but he will wake up about half an hour to an hour later and say I'm not tired anymore and then I've got to go back up to him and try and sort of settle him again and then I settle him and then he wakes up again and you know, you're up and down. So the relationship between you and your husband or your partner is non-existent"

"I think that's because I've dealt with it that way. I think if I was more open minded I'd be venturing out a lot more... And because I feel like I've had to cope with a lot of other things, I'm not sort of I suppose dealing with it very well. I mean my mum would say you're a perfect mother and you're doing brilliant Linda. He's fine, he's healthy ...But ...I've tried to do the best I possibly can for Nathan and I've tried to ensure that whatever I'm going through hasn't reacted on him. Now maybe I've ... it has reacted on him, maybe the expression on his face would tell a different story sometimes, but I have really tried to sort of put it to one side when I'm in front of Nathan".

"Yes, I mean I would like to be my old self more so, but I don't know, I don't know how you can actually do that when you've got a child. You've just got to deal with the situation at hand haven't you and ... I think it's down to the individual or the parent should I say. If they can deal with it OK then everything sort of works round it doesn't it. But if you don't deal with it, then everything goes haywire and all over the place".

Time then is seen as a critical factor in the management of childcare, 'it's all time limitations'. Yet in the next extract Linda blames herself for not having 'put Nathan into a pattern', for having in practice ignored 'time limitations'. The analogy to 'front' and, by implication, back stage is also interesting in the management and presentation of self as a coping mother. Linda ponders what 'different story' her son might tell whilst asserting her attempts to 'put it to one side when I'm in front of Nathan'. Linda also acknowledges that her 'old self' can never be fully regained because she now has a child, the implication is that the enormity of the changes means there is no going back. Ironically a thread running through Linda's antenatal narrative concerned her perceived loss of control around her body shape. Her own weight, and her views on those who were 'fat', was a recurrent theme. In contrast the birth of her child has led to a shift in her perception of self(s),

"I think because of you know that again the situation that I've been in, I've just lost weight...I think if things had been different I probably wouldn't be the size that I am, as thin as I am...I mean I was about 8½ stone before I was pregnant and now I'm 8. And I've just gone *[sound effect]* ...I'm not so concerned about my weight, I'm just sort of ... I'm concerned about my physical feelings, my tension, my ... you know, I feel sort of very worked up inside and something feels like it's just going to blow. What that would be, I don't know. My top most probably".

Linda also feels that her husband's perception of her has changed,

"My husband has said to me, I just see you in a different light. I don't see you as perhaps the person that he married. He sees me as a mum full stop. And that hurts because of inside I don't feel like that mum and I want to be much more than the mum, but I suppose it's watching the birth".

"He said it was awful. He said to see someone in pain, to see something coming out of your woman then, because of you are, you're their girl aren't you and then suddenly you're like this big, this big person that's sort of parading around with swelled up feet and all sorts and then you give birth to this baby and it's like *[sound effect]* it's such a blow. You know..one can pay for that..I can tell you".

Becoming a mother then has involved all sorts of unforeseen and unanticipated changes which Linda feels no one could have prepared her for,

"But then I don't think anybody could actually honestly say this is how I'm going to cope with it until it actually happens, until the baby's you know in your arms, because I never knew that being a mother would completely change my life. I thought, naively I thought that I'd deal with it and cope with it like I dealt and coped with work and you know everyday life beforehand".

"No, no-one trains you. You know, you go for training to be in charge of other people or to deal with different situations, but I mean when you're at work and you say, do that, you expect them to do that. But you say to a baby, no, and they'll just look at you and laugh and say, well I've have another go until you probably sort of shout at me. But I mean he doesn't know 'no', but then he's only tiny, he's just sort of totally vulnerable isn't he, can't do anything for himself can he, except for cry!"

"No, you just don't know how to deal with it. No-one says to you, again no-one puts you in a category and says, this is how you make your husband or your partner respond to you in the way that you want. They just all deal with it in different ways, don't they?"

The enormity of the changes brought about by the birth of a child are clear, 'I never knew that being a mother would completely change my life'. The experiences lived through since the birth of her child has led Linda to reassess her abilities to cope with situations. Previous experiences of 'work and you know everyday experiences' are cited in terms of their *difference* to the work involved in coping as a mother. In the workplace Linda was a competent, and coping, social actor. Linda also refers to the discipline of the work place 'when you're at work and you say, do that, you expect them to do that', and how such an approach does not work with a baby. What is interesting here is the tentative voicing - 'until you probably sort of shout' - around the matter of disciplining a child and the underlying acknowledgement that there are 'good' and 'bad' ways of disciplining a child, and shouting might not be considered 'good'.

By the time her child is nine months old, Linda is able to narrate the difficulties she has lived through since the birth of her son, to reveal that her experiences did not resonate with her expectations. During the earlier postnatal months, when Linda chose not to be interviewed it is possible that she felt unable to narrate the 'chaos' she was experiencing. As Frank has noted, "lived chaos makes reflection, and consequently story telling impossible" (1995:98). The following extracts suggest that the early postnatal weeks and months were lived in turmoil,

"Yes, I think, like I say you never forget the pain, and I think I've blanked out a lot, that's why I feel that I've missed out on a lot because I've blanked a lot you know the months out of my mind"

"I can cope, I mean I'm coping with it. But I mean with Nathan, he's just fine. I mean he's interested in going through my bag at the moment... But no, I mean, I just think it's ... you know other circumstances have made me ..."

"I haven't... I don't know that I'd have dealt with it in a different way. But I just feel that some people would say to me they keep these books, you can actually get these baby books can't you that says the first smile, the you know, when all these different questions. And I can't exactly remember all those times. All I remember is him crying because he was colicky and you know having to deal with it on my own and that was such a lonely time".

And although Linda now feels able to voice these difficulties, in the following extract she talks of still feeling 'it's all a daze',

"No, no. No. I feel like I'm an in-between. No, I mean I don't know what a mother is meant to feel like. No-one can be a perfect, perfect mother but I try and do my best, and I just feel at the moment that it's all a daze, you know it's ... I'm not Linda until I go out on my own, perhaps socialise with other people....I don't know what I feel really. I mean I don't feel like a mum and I don't feel like my old self, but then I'm not working anymore, I'm not sort of socialising in the circles that I was at that time".

The analogy to being 'an in-between' is emphasised in terms of being between self(s) 'I don't feel like a mum and I don't feel like my old self' and existing between 'worlds', no longer in the world of work and not (yet) feeling comfortable in the private sphere in which most mothering and childcare takes place. Later in the interview the private sphere of the home is again referred to,

"And when you see other people, you see them for face value, but when they go home is it a different story and do they actually tell you? And no, I don't think they do and that annoys me because I think to myself I know what I've been through, or we as a family have been through and I'd love other people not to know that it's us but to know that it's not all hunky dory and you've not failed if something has gone wrong ..."

In many ways this extract illuminates all those that have gone before. It raises questions about whether and how people feel able to voice their experiences, the layers which lie behind 'face value', and also the acceptability of particular accounts in the different public and private spheres of our lives. Clearly there are perceived moral dimensions to public accounts which Linda wishes to challenge, 'and you've not failed if something has gone wrong'. Linda feels angry that difficulties are often concealed 'and do they actually tell you?', resulting in the

myths which surround motherhood remaining unchallenged. Perceptions then of what constitutes 'normal' transition, in which women *naturally* take on the role of mothering, persist.

Final Comments.

In the end-of-study questionnaire, Linda used the space which asks participants to describe their experiences of being in the study, to make the following comments:

"I would hope being a participant in the research would help other women, as I felt it very interesting to listen to the tape of myself whilst being pregnant. Tina is making a great achievement for women, I hope in enlightening us all, that we are allowed to feel the way we do. Well done Tina and thank you". (See Appendix 8)

Having revealed in her final interview the difficulties she had experienced since becoming a mother, Linda's tone is now almost zealous. Voicing her difficult experiences appears to have been cathartic. Linda comments that she has found listening to the tape of her earlier antenatal interview 'interesting' and the implication is that it may have been 'therapeutic' in some way (see Chapter 8). Her perceptions of the research as 'enlightening us all' and enabling women 'to feel the way we do' is gratifying and at the same time of some concern. This is because it suggests that our perceptions of the aims of the research differ and although at an individual level Linda has found being a participant in the research helpful - which is welcomed - I recognise that the shifts required to bring about the changes she alludes to, at societal level, are only very gradually achieved.

Concluding Discussion.

Difficult experiences then can be difficult to voice. Frank, writing in a different context, notes the "paradox that a true chaos story cannot be told" (1995:105).

Crucially mothers can only narrate 'chaos' once they feel they are coping - a mother cannot admit to not coping until she is able to reflect from a position of strength. The passing of time, and ability to reflect, offers the possibility of

reconstructing narratives of experience, enabling more 'public' versions of transition to motherhood to be challenged.

What Linda's narrative demonstrates is the ways in which as social actors we can select and narrate particular events in order to present a particular self. The 'strategic' use of narrative has been explored in the work of Reissman (1990) who asserts that "we are forever composing impressions of ourselves, projecting a definition of who we are, and making claims about ourselves and the world that we test and negotiate in social interaction" (1990:1195). Linda uses her narrative 'strategically' (Reissman, 1990) to convey her success in the public domain and to demonstrate the ways in which she *was* able to operationalise agency - she was financially successful, independent and in charge of other people. The world of work outside the home then had clear boundaries whilst mothering is all encompassing¹. Linda talks of her competencies in the world of work, in order that the difficulties she has experienced in terms of mothering work can be placed in context. She *has* been a competent social actor - in the world of work. In her study of changes in self identity in the transition to motherhood, Bailey also found that "repeatedly, the women talked about the importance of their work to their sense of who they were" (1999:341).

Linda's narrative is littered with references, both explicit and implicit, to different worlds and front and back regions. So, whilst Linda has attempted to conceal her difficulties and unhappiness from her child, 'I have really tried to sort of put it to one side when I'm in front of Nathan', she is left wondering how many others

¹ It is acknowledged that women working outside the home may be in a position which enables them to make choices about where and how they work. Phizacklea and Wolkowitz in their book, 'Homeworking Women. Gender, Racism and Class at Work' (1995) note that "some middle class women have the resources, in the form of high earnings, to avoid some of the problems of working at home, for instance through employing nannies and childminders" (1995:125). All the women in this study had worked outside the home. It would be interesting to explore the ways in which becoming a mother impacts on the identities of those who are involved in homeworking, where boundaries between particular worlds may be less clearly defined and differently negotiated.

conceal their experiences, 'but when they go home is it a different story and do they actually tell you? The ways then in which particular narratives - the 'good mother' narratives (Garcia Coll et al, 1998:12) - are culturally embedded, makes voicing difficult experiences problematic. A return to the world of work offered other women in the study an opportunity to present their selves in a different setting. A setting where the opportunity (might) exist for them to operationalise agency without being perceived as a mother. However for those who do not return to work outside the home, the opportunities are more limited. In both locations the problems of voicing difficulties around mothering remain, but the work place can provide a context in which women can confirm competencies which had been challenged by early mothering experiences. Paradoxically, the good mother narrative also shapes perceptions of mothers who work outside the home². The pervasive dimensions of 'good' mothering narratives are then hard to escape.

² It is acknowledged that the size and shape of the female workforce recruited, is driven by economic factors and other societal demands (see Chapter 9).

Chapter Eight

Methodology Revisited.

Introduction.

In this chapter the methodological concerns which have arisen as the research has unfolded will be (re)considered. Carrying out qualitative research necessitates sensitivity and continual reflection on the ways in which decisions, taken over the course of the research, can influence and shape the final product. Inviting and collecting accounts of a period of uncertain personal transition raises issues around access, the nature of the research relationship and notions of 'informed' consent. The role of the researcher as both catalyst and interpreter requires continual monitoring of decisions taken. The timing of interviews may similarly have implications for what is voiced. Using examples from participants' interviews and the end-of-study questionnaires, these areas are explored below.

In setting out to collect narrative accounts of experiences of first time motherhood, the aim was not to discover objective truths, but rather to collect diverse and dynamic accounts of individual experiences. "When talking about their lives, people lie sometimes, forget a lot, exaggerate, become confused, and get things wrong. Yet they are revealing truths...the truths of our experiences" (Personal Narratives Group, 1989:261). What is revealed, or retained will be dependent on many factors, but in the research setting, how the interviewer is placed will be a contributing factor. Plummer has described the researcher in such interview encounters as a "coaxer" and describes the "constant flow of joint actions circulating between tellers, coaxers, texts, readers and the contexts in which the stories are told" (1995:24). The ways in which participants are accessed can also affect not only how the researcher is placed, but what is told. In this research the

relationship of one gatekeeper to the participants she helped me access, had unforeseen consequences.

Access: the Potential of the Gatekeeper.

The ability of 'gatekeepers' to exert leverage in the research setting has previously been documented (Miller, 1995:303). But the ways in which gatekeepers, through their relationships with participants can, in longitudinal research, continue to exert an influence over whether and how a participant feels able to speak is less well documented. The potentially inhibiting influence of the relationship between gatekeeper and participant was clearly illustrated in one particular case in this research. Two of the participants were related by marriage and both had been located through an acquaintance of mine who lives in the same locality. Once initial contact had been made, the gatekeeper arranged that both interviews should take place in her home as both participants lived some distance away, although I had made clear my willingness to travel to their homes. Whilst the two antenatal interviews went well, by the time the first postnatal interviews were due, one of the participants was clearly experiencing difficulties (as she later commented), not in coping with the new baby, but with the effect the birth had on her marriage - to the brother of the gatekeeper. This participant initially 'chose' not to be interviewed when the first postnatal interview was due (see Chapter 7). This action raised several important issues. The need to re-negotiate access at each stage in longitudinal research was highlighted. So too was the dilemma of how to respond to a participant who is clearly, by her own account, experiencing unhappiness and appears to be 'silenced' by others. Another awkward issue for me concerned being in a position of having gathered data on aspects of the participant's life and subsequently experiencing pressure from the gatekeeper (her sister-in-law) to let her know 'what was going on'.

The participant's anxiety that the gatekeeper (her sister-in-law) might find out what she had said in her interviews was also apparent. She was concerned because she said she had sounded 'negative' during the interviews (revealed her personal sense of self in her account which did not fit with the public and/or her sister-in-law's account of becoming a mother?). I reassured her that I was ethically and professionally bound to observe confidentiality and could not relate anything she had said to her sister-in-law. In fact her sister-in-law had expressed a keen desire to find out the contents of the tape, even telling my children that I had a tape recording she would like them to help her get her hands on! (see Appendix 8 and comment regarding the tape in the end-of-study questionnaire from this gatekeepers sister, another participant in the study). The potential power of the gatekeeper, to influence whether and how women feel able to voice their experiences (or whether self disclosure is perceived as too risky), needs then to be considered throughout the research process.

Inviting Narratives.

The invitation to construct and present narratives of experiences has become increasingly popular as a research tool. But asking a participant about lived experiences (usually) requires them to reflect, possibly re-evaluate and re-order past experiences, to make sense of what has happened to them. The narrative interview then can be seen as closely allied to the therapeutic encounter, and yet the blurring of these boundaries raises some concerns. The psychotherapeutic method of telling stories uses self reflection in a systematic way, and inviting individuals to reauthor their story is recognised as "a distinct method in many formal therapeutic settings" (Birch and Miller, forthcoming). I have already written of my own unease at being cast in the role of therapist/counsellor (see Chapter 3) and in the following extract such

an interchange is discernible. The extract is taken from a verbatim transcript of a final interview,

Kathryn: "...you know when I had all the problem with the anorexia that the psychiatrist that I saw said that I was one of the strongest people she had ever met and how amazingly in control of my emotions I was and I think that's probably it, and that probably explains why still I think that Rupertthere we are, you've sorted out all my feelings"

Tina: "I suppose it is, it fits...It fits. You've got your emotions so tightly screwed down about your...about him. I mean obviously I'm not here...I'm not a psychologist...."

Kathryn: "No, there we are"

Tina: "...well you've sorted it out yourself"

I remember driving away from the interview feeling responsible for having unleashed, rather than 'collected' this women's experiences. I felt concerned that my interview had encouraged the participant to reflect on her past and re-evaluate it, and I was naïve not to have contemplated such an outcome. Later during the analysis stage of my research, on returning to this transcript, I felt some disquiet in that the interview had been 'used' as a therapeutic opportunity by someone who had previous experience of such an encounter, whilst I did not. Now, as I write up, I feel much more ambivalent about the interaction, I am able to reorder my own experiences of the interview and to make sense of the encounter in different ways. The comments made in the end-of-study questionnaire by this participant also demonstrate her experiences of being part of the research, and in so doing probably absolve me from further worries,

"The subject of pregnancy and motherhood is so intensely personal that one is often reluctant to discuss it openly...with my baby at eight weeks old, so much had happened and so many changes were taking place almost daily that it was hard to assimilate everything and the second interview helped to consolidate my feelings. Nine months later I had come to terms with the enormity of the changes and it was helpful to analyse - through the research project - why I had reacted in certain ways to different things" (Kathryn: end-of-study questionnaire).

However, I continue to feel that the blurring of boundaries between sensitive research encounters and 'therapeutic' encounters raises important considerations for feminist researchers. Whilst embracing the principles of sensitive research, the qualitative researcher must continually consider the potential implications of inviting individuals to engage in a reflexive project which may lead to the revisiting of unhappy experiences. Whilst this may lead to new understandings being achieved, it may also result in a need for the researcher to support the participant in accessing other forms of 'professional' help, or to consider providing support themselves (Oakley, 1992). Indeed there may be a need to consider the production of guidelines for researchers involved in this type of research.

Inviting individuals to narrate their experiences through transition may lead them to reflect on their experiences in ways that they may otherwise not have. Duncombe and Marsden have commented upon the ways in which the qualitative research interview can "take a form of direction that leads respondents to betray more of their private selves than they would upon reflection wish to expose to the gaze of an interviewer" (1996:143). The researcher then can be seen as a "coaxer" (Plummer, 1995:24), "co-producer" (Corradi, 1991:108) and potentially, a catalyst. In the following extracts taken from interview transcripts and the end-of-study questionnaire, participants in the research allude to how being part of the research will, or has, encouraged them to reflect. The first extract contains an exchange between Gillian and myself when we met for a first antenatal interview and illustrates how Gillian had anticipated the interview,

Tina: "What have you enjoyed most about being pregnant?"

Gillian: "It's funny 'cos I was hoping you weren't going to ask that sort of question".

Tina: (Laughter) "You don't have to answer it if you don't want to!"

Gillian: "I was wondering this morning what you were going to ask ... hope you don't ask me what's the worst bit"

Tina: "That's next actually!" (laughter all round).

"I'll think about all these questions and I'll think, you know, god, I haven't asked myself that, and you know, how is life going to change, and ... I have, I've thought about it, but not really asked myself, you know" (Lillian: Interview transcript).

"The interviews themselves were extremely adept at making me consider certain issues and feelings which I might otherwise have dismissed. It was also fascinating to look back at the way in which I had responded in previous interviews and then to consider my changing views and feelings. It also helped me to rationalise my otherwise irrational thought processes. I thought the interviews were timed to perfection, possibly because the researcher was a mother herself and therefore understood the amazing swing of emotions during that very short period...in relation to life before baby, once you have accepted that the life you are now living is yours - not someone else's, and that the baby is here to stay" (Diana: end-of-study questionnaire).

"I found the interviews very thought provoking and good for myself because it gave me time to sit and reflect on my life and also to see how my views changed once babies arrived" (Sheila: end-of-study questionnaire)

"At the third interview I didn't recognise any of my answers to the second one...I always thought of lots of things I'd wanted to say after the interview was finished, but of course had forgotten them completely by the next interview" (Peggy: end-of-study questionnaire).

"I remember when you know I was in hospital and things I thought oh, I'll have to tell Tina this, I'll have to tell Tina that" (Philippa -Interview).

Whilst the interviews provoked participants to reflect, the timing of interviews was also a clear factor in how accounts were constructed and presented. As Sarah informed me in one interview, I had got her on a 'good day',

Sarah: "And you have caught me on a good day".

Tina: "Oh right, and that, so what is a bad day like?"

Sarah: "I just wander round moping".

Similarly, in the following extract, Felicity's comment on the timing of the interview illuminates the tenuous nature of narratives,

"I mean it would have been really different because, I remember thinking after I'd had Harry in subsequent days and I thought if Tina came and spoke to me and asked me these questions now about how the birth was, it would have just been so awful" (Felicity - Interview).

Just as the timing of an interview has implications for what is said, or what can be said, so individuals make decisions about how and what to say. Rebecca demonstrates this process in the following extract,

"Felt I could discuss almost anything - did keep a few personal things back - I felt very out of control in the first couple of interviews but felt much more like myself in the last one" (Rebecca: end-of-study questionnaire).

What is voiced in an interview can clearly, although not always, be influenced by the interviewer, as well as the participant: it is a co-production. In research involving transition to motherhood what can be voiced about experiences will be constructed within the context of particular notions of culturally acceptable ways of talking about motherhood. In endeavouring to collect and listen to women's accounts of becoming mothers, I sought to create an atmosphere in which diverse experiences could be voiced. I was interested to note in the following extract my own lengthy contributions to what I perceived were difficult to voice experiences,

Tina: "Right, so was that decision ... I know when I met you at 8½ weeks you said you were going to ... to ... back to work after ... in January, but that you didn't like to think ... you know, weren't allowing yourself to think about it at that point".

Kathryn: "I think the ... the only sad thing about coming back to work was that I knew from the start I'd got to do it and I wonder whether I let that affect my bonding with him, because I don't think I bonded with him. I don't know, I don't know how other mothers feel, but I certainly ... although I love him terribly I was talking to another mother last week because we in fact went away to Egypt, Christopher and I had a week, a week's holiday, ten ... whatever, ten days, just before Christmas, my mother had him. And ... it wasn't difficult to leave him. I mean it wasn't ... it wasn't easy but I didn't pine for him while we were away. I did look at my watch and think, well I wonder what he's doing now, because he had such a good little routine I knew exactly what he'd be doing and when, but I didn't ache for him, and this other mother was saying, gosh, I don't know how you could possibly have left Rupert, I just simply couldn't, and you know there she was clinging on to this little baby, and I'm quite happy to let him go to people, and in the surgery last week he was crawling around and a lady had suede shoes on and he loved the feel of her shoes and then another little ... another man said oh come over here and he crawled up and sat on his lap, and I'm really happy for him to do that, and people love a baby who will be that. But I worry sometimes whether I'm ... I'm too laid back about him, that I don't worry about him or I don't ..."

Tina: "Yes, I don't know, I mean it's difficult. I have friends now who can't believe that I can go away to a conference for a weekend and really look forward to it, and I mean yes, I feel guilty because I know that they're all missing me and then I ... I was away last week actually for three days and I phoned on Friday to speak to the girls before they went to school and Freya said you know, mum, can you make our sandwiches next time before you go away because dad's just aren't the same. But you know their father goes away all the time. He's always ... he's abroad a lot and it's not ... you know that's all acceptable, I think there are sort of ... I mean I know my mother said she couldn't have left us and I can quite happily leave mine. And I don't think it means I love them any less, but I can ... I can do that. And actually I think it's quite important to ... to find some time where you can do that, which does mean that you've got someone who you can trust to look after them".

Kathryn: "Well this is it. I mean with Fiona ... Fiona's so good ... she's our nanny who's so good with Rupert and so gentle and has so much time for him. I really don't worry and I come to work and I do my job and then I come home. I must admit I love coming back at lunchtime and seeing him, and I do really ... if I do ... if I do miss him at any lunchtime then I do ... I really miss that and I look forward to that and I look forward to coming home at the end of the day, but to me it's just right and actually ..I mean I admit this to you and it'll be on the tape, but at the end of the weekend I'm thinking phew, thank goodness somebody else has got part of the day, which is an awful thing to say maybe?"

Tina: "Well I ... but I think that's part of the sort of the unacknowledged hard work of being a mother".

Clearly, I am attempting to reassure Kathryn that her feelings are not unusual, to give her 'permission', through an example of how I have felt and my experiences, that how she feels is not abnormal. This approach then is far removed from any pretence of objective data gathering and shows the ways in which researchers are inextricably located within their research. As Stanley and Wise have noted, "all human attributes are brought into the research situation by researchers, are inevitably brought into it, whether this is library research or research 'in the field'". (1993:58).

Interpretation.

All research is based on interpretation at differing levels. The longitudinal dimensions of my study enabled me to return to participants on two further occasions following the first interview. Prior to these subsequent interviews I read and incorporated extracts from the transcripts of participants previous interviews. I decided what I thought was interesting, relevant, ambivalent in their accounts. I *interpreted* what they had said and used this to shape our

next encounter. As The Personal Narratives Group have noted, "the truths of personal narratives are neither open to proof nor self evident. We come to understand them only through interpretation, paying careful attention to the contexts that shape their creation and to the world views that inform them" (1989:261). As a sensitive feminist researcher I have paid 'careful attention to the context' in which narratives are constructed and presented, but also acknowledge that the demands to produce a particular product - in this case a Ph.D. thesis - has implications for interpretation and presentation. Whilst wishing to retain the voices of the women in the final research account, the extent to which this is possible can be inhibited by other demands, for example word length in Ph.D. theses. Presenting research of private lives into the public arena of academia also raises concerns. The ways in which powerful "predominant Western knowledge forms", dominate the academic world is explored by Edwards and Ribbens (1998). They note that discussions which have arisen in relation to researching non-Western experiences and lives also raise questions for those researching marginalised Western social worlds and private lives. They go on to suggest "that this power in discourse may be seen to be similarly operating when we research private lives in Western societies and then translate them into a representation that is acceptable to public academic audiences" (1998:3). The voices then that are being presented have been *coproduced*, interpreted and ultimately shaped for an academic audience.

Producing a piece of research for any audience requires that participants experiences are sensitively incorporated. In research where participants may be known to each other the need to be sensitive in writing up becomes even more critical (Mauthner, 1998). In publications which have already resulted from my research for this thesis, (see 'Declaration') I have changed some details of individual's lives which would have made them identifiable, for

example changing the nature of an eating disorder. Whilst I do not really anticipate that the participants will ever read any of these publications, or this thesis, I wish to err on the side of caution. I have offered to send a summary of the findings from this project to all those women who took part, and I am aware that this will have to be carefully crafted so that identities of participants known to each other are concealed. I am also concerned that they will not 'recognise' the research project they entered and this leads me to consider the question of 'consent'.

Informed Consent to What?

In most research, participants consent either verbally or in writing, to be a participant in the particular study. Consent is something, we are told in research handbooks and ethical guides, which must be obtained prior to any research commencing. Yet, what is it that participants are consenting to when they agree to join a study? If the focus of the research is to explore a period of transition, how can the outcome be known? If knowledge production is grounded in individual experiences the course of a project can only be guessed at, the final shape of the product only becoming clear at the end of the study, ultimately shaped by the researcher. Feminist principles of research (reciprocity, empowerment etc..) may be embraced by the researcher at the outset, yet goals may shift, prompting a more instrumental approach, for example meeting deadlines. Whilst the dynamic nature of the research process has been acknowledged, the ethical dilemmas that this presents for feminist researchers and their research participants are less well explored. Obtaining 'informed consent' at the start of a project should not mean that it does not have to be thought about again. I feel some trepidation in returning to the participants in my study with a summary of the 'Findings' as I feel certain they will have anticipated a different 'product' when they

agreed to join the research. At the same time I am aware that some will have completely forgotten about it altogether¹.

Methodology Revisited: Some Reflections on Strengths and Weaknesses.

Looking back over a piece of research enables reflection from a different position to that occupied at the outset. From here, the strengths and weaknesses of the research are clearly discernible! The weakness that I particularly regret was that a more socially mixed group of women was not accessed as had originally been planned. However I am comforted by the interesting insight into individual's perceptions of 'social class' as illustrated in the end-of-study questionnaires, and feel that the participants were more diverse than might at first have appeared to be the case. The significance of the world of work to women's lives as they entered the new world of motherhood was unanticipated by me. But I am extremely grateful that the participants had all been women with paid employment outside the home, to bring the significance of 'different worlds' into relief in this context. The longitudinal component of the research was planned and turned out to be crucially important. Collecting women's experiences over time brought in to focus the differing time frames that exist between professional practise and lived experiences of mothering. I acknowledge that 'longitudinal' in my project is relative - a period spanning approximately one year in women's lives - but a longer period would not have been feasible within the framework of studying for a Ph.D. (This does not preclude a possible return to the participants - with their agreement - at a later date to build on this piece of research). The idea for the end-of-study questionnaire was decided upon only once the project was underway. Yet the data contained in some of

¹This was demonstrated in one response I received when I wrote to confirm participants addresses before returning their tapes to them. Abigail replied to my letter and, as well as confirming her address details, wrote "...it seems so long ago, that to be honest I'd forgotten about it".

these 'questionnaires' has served to illuminate earlier accounts, helping with the interpretation of what had been said in earlier interviews.

The questionnaire also, unexpectedly, provided me with an opportunity to disengage from the research setting whilst keeping lines of possible communication with participants open. I discussed the end-of-study questionnaire with participants in the final interview and these were despatched a few days after this meeting. Amongst other things, the questionnaire invited participants to tick a box signalling their desire to receive details of the findings of the study and to provide their address for this purpose. As I still have to produce a summary of findings, I don't yet feel I've fully *disengaged* from the research setting: a tenuous, but in some ways comforting, link remains. The sharing with me of private and personal experiences of transition to first time motherhood placed me in a very privileged position. I shall always be grateful to the women who allowed me in to glimpse *their* journeys.

Chapter Nine

Concluding Discussion.

Introduction.

In this thesis I have explored the ways in which women make sense of their experiences of becoming mothers by focusing on the ways in which narratives are constructed/reconstructed and strategically presented. In this chapter it will be argued that transition to motherhood is experienced within the context of *differing* professional and personal time frames: the one largely rooted in assumptions of biological determinism and science, the other socially located and grounded in experience. The collection of longitudinal data, as seen in Chapters 4, 5 and 6, bring these differences into relief. Within these competing time frames around the same event, epistemological and ontological shifts take place. Over time, as engagement with expert knowledge lessens, the women ultimately becoming the experts on their own babies. In turn, epistemological and ontological security lead women to eventually feel able to challenge assumptions around mothering with which they may have previously collaborated. The strategic use of narratives also shifts over time, with personal layers within narratives becoming more discernible in later accounts. Feeling able to cope can lead to the voicing of past, difficult experiences. A study of narrative then enables an exploration of the ways in which women negotiate and narrate their journeys into first time motherhood. The resulting accounts prompt consideration of the ways in which professionalised care is currently organised around childbearing. Thus, later in this chapter I will go on to consider how policies in this area may be changed.

The Shifting Context.

The social context in which women negotiate and narrate experiences of mothering and motherhood has been shown to be multi-layered, dynamic and one in which contradictory processes are often at work. Similarly, women experience this social context in different ways. As Stanley and Wise have noted, "the experience of 'women' is ontologically fractured and complex because we do not share one single and unseamed material reality" (1990:22). Childbearing is one biological event that many women will share, but birthing and mothering *experiences* are diverse. The constant tensions between perceptions of mothering being 'natural' and therefore instinctive, and the lived experience of mothering being, for some, difficult and not 'natural' provides a challenging setting in which to make sense of, and voice, experiences. An understanding of how women make sense of this period of transition is achieved through a focus on narrative. Narrative "allows us not only to tell what happens but to impart how an event takes on meaning for us, to convey the double landscape of *inner* and *outer* worlds" (Mattingly and Garro, 1994:772). Transition to motherhood can, and usually does, involve engagement with 'expert' (professional) knowledge involving, at times, competing knowledge claims leading to epistemological struggles. Becoming a mother also involves ontological shifts for many women, from ontological security to periods of ontological insecurity. This is mirrored in shifts in self-identity, and the need to negotiate a sense of self, within the context of other identities, in a new 'inner' world of mothering. In turn this raises questions of competing perceptions of 'normal' transition.

The contribution of feminisms to debates on the relationship between epistemology and ontology have "sent us to new methods and places,

and has encouraged the hunt for new sources of insight into women's realities" (The Personal Narratives Group, 1989:263). In conjunction with this, an interest in the reflexive self has characterised much social thought in late modern society and prompted new ways of thinking about social action. Informed by the work of Giddens (1991) and Beck (1992), Bailey has recently sought to explain this shift in the following way, "no longer able to draw on a traditional order, we have to explore reflexively personal and social change, and are increasingly dependent on experts in helping us to negotiate *rites de passage*" (1999:335). Transition to motherhood in the late 1990s is negotiated and experienced within this context. Hand in hand with this focus on the reflexive self has been a growing interest in the role of narrative in presentation of self and the construction of identities (Plummer, 1995; Reissman, 1990; Polkinghorne, 1988; Birch, 1997). Individuals then make sense of experiences and project particular self identities through narrative. As Reissman notes, "we are forever composing impressions of ourselves, projecting a definition of who we are, and making claims about ourselves and the world that we test and negotiate in social interaction" (1990:1195). Attending to an individual's narratives is not then about a search for objective 'truths', but rather an attempt to understand the ways in which connections are made between social processes and structures and individuals' strategic uses of narrative (Plummer, 1995). As Frank has noted "the social context affects which stories get told and how they are told" (1995:3).

The shift in emphasis to focus on subjectivity clearly has implications for notions of theory. Feminist debates around such fundamental questions as to *what* constitutes knowledge and *who* says what counts, have led to more accessible ways of thinking about the role of theory in

social thought. In many ways theory, particularly that described as 'grand theory', has existed in an abstracted form apparently unrelated to lived experience, but enjoying a privileged position. In their questioning of taken-for-granted assumptions around women's lives, feminists have been instrumental in challenging the relevance of abstracted theory and indeed 'alienated' knowledge (Griffiths, 1995; Stanley, 1990; Stanley and Wise, 1993; Ribbens and Edwards, 1998). The crucial underpinning of experience in any theorising is recognised by Stanley and Wise who argue that "the relationship between feminist epistemology and feminist ontology is one which positions ontology as the foundation: being or ontology is the seat of experience and thus of theory and knowledge" (1993:192). At one level then, in using our experiences to make sense of the social world, "we are all of us 'theoreticians'" (Stanley and Wise, 1993:64). But this has not always been acknowledged, possibly because it demystifies, and challenges, the relevance of the edifice of mainstream 'traditional' theory. Some experiences have not been regarded as relevant to macro level social sciences. For example, the concepts of 'public' and 'private' only more recently helping to illuminate the ways in which "the history of the social sciences as disciplines (are) rooted within public domains" (Edwards and Ribbens, 1998:8). Women's experiences of family life in the private sphere, which are always contingent on experiences in the public sphere, has only more recently been explored and made visible (Ribbens and Edwards, 1995, 1998). The rejection of women's experiences in the private sphere as important or as relevant to wider social structures is implicit within the observation made by Ross who remarks that "telling the hard things

¹I recognise that the terms 'public' and 'private' are ambiguous concepts. Edwards and Ribbens (1998) provide a useful discussion of these concepts in their introductory Chapter, 'Living on the Edges. Public Knowledge, Private Lives, Personal Experience' in their book 'Feminist Dilemmas in Qualitative Research' London:Sage.

about motherhood has usually been labelled gossip and been confined to womens' private conversations on playgrounds, doorsteps or telephones" (1995:398). Recognising and valuing the 'hard things about motherhood' from the experiences of first time mothers, and making them visible, has then been the focus of this research.

However negotiation and social interaction around transition to motherhood takes place within generic social processes and particular cultural locations, and narratives are both formed and informed by these contexts. Agency then is contingent on structural and materialist boundaries. This point is powerfully made by Patricia Hill Collins. Writing about experiences of motherhood she notes "motherhood occurs in specific historical situations framed by interlocking structures of race, class and gender, where the sons and daughters of white mothers have 'every opportunity and protection', and the 'colored' daughters and sons of racial ethnic mothers 'know their fate'. Racial domination and exploitation profoundly shape the mothering context, not only for racial ethnic women in the United States, but for all women" (1994:45).

Differing Professional and Personal Time Frames.

The participants in this study were all white, working women, who were expecting their first child. The journey into motherhood had for the most part been planned. The context in which they anticipated, experienced and narrated their transition to motherhood contained elements that were culturally embedded, yet lived experiences were diverse. The data collected over the course of the longitudinal study revealed the shifts which occur in the ways lived experiences are narrated, how "people say certain things at certain times and in certain places, and likewise not to say them at others" (Plummer, 1995:172).

The women's narratives were framed in relation to their previous experiences, especially in relation to the world of paid work outside the home, and were contingent upon their perceptions of appropriate - and 'normal' - transition to motherhood. Professionalised care formed the backdrop within which their expectations and experiences were, at different times, mediated, validated and made sense of. However, as I have argued, analysis of the participants' narratives collected over time, revealed that differing professional and personal time frames operated around their transition to motherhood.

Graham and Oakley (1986) have previously written about the competing medical and maternal perspectives on pregnancy. They employ the concept of a 'frame of reference' to indicate the "qualitatively different way of looking at the nature, context and management of reproduction" which they found existed between doctors and mothers (1986:99). However, careful exploration of women's narratives *through* pregnancy and early mothering experiences, reveal a further dimension to the different frames of reference identified by Graham and Oakley; that of differing *time* frames. Crucially, the time frame within which professionalised care operates is rooted in the contradictory assumptions of biological determinism and science, of women's natural abilities to become and be, mothers. In contrast, women's lived experiences of becoming mothers, dictates a differing time frame which must accommodate the frailties, contradictions and complexities which underpin a shifting self through transition². These differing time frames

²It is at the same time acknowledged that women's thinking about childbirth, their lay beliefs, will have gradually been affected by 'medicalisation', that aspects of medicalisation will have become 'culturally embedded'. (see Jocelyn Cornwell, 1984 'Hard Earned Lives')

become more apparent as transition unfolds and ontological shifts and competing knowledge claims are encountered.

The narratives collected during the antenatal period showed women as willing collaborators in their professionalised preparation for motherhood. They attended clinics, welcomed and sometimes actively sought, ultrasound scans, joined parentcraft classes etc. Far from resisting engagement with medicalised childbirth, the participants willingly entered into relationships with health professionals, perceiving them as the experts, and appearing to equate engagement with safety. Forms of pain relief were not resisted, but ranked in terms of their perceived benefits, and for some seen as a means of retaining control and therefore potentially liberating. Interestingly, in their recent paper, Revisiting the critique of medicalised childbirth, Fox and Worts (1999) note the tendency in much feminist analysis of childbirth in the past "to overlook the agency of women who accept medical management of their births" (1999:329). The participants in my study could be seen to exercise agency within perceptions of the hospital being the culturally acceptable, and 'natural' place to give birth. During this antenatal period, the women's expectations mirrored those of the professionals; contradictory stories from friends of difficult experiences were regarded as 'unhelpful'. Notions of a 'normal' transition to motherhood were largely 'shared' by the professionals and the participants and, importantly at this point, *similar* time frames could be seen to operate in relation to anticipation of the birth. Birth 'naturally' occurred in the hospital and medical assistance might be required to help the natural process. The women then could be seen to have particular, culturally embedded, ideas about appropriate preparation for motherhood.

The context in which transition to motherhood is negotiated and experienced then, is permeated by notions of 'normal' and 'good' and 'bad' mothering. The narratives collected during the antenatal phase were constructed in relation to such notions. Urwin (1985) charts the "construction of norms" underpinned by scientific knowledge in relation to the development of professional ideas which exist around baby/childhood practices and "the persuasion of normal development" (1985:164). Similarly Coll, Surrey and Weingarten (1998) have noted the pervasiveness of 'norms', "for most mothers it is impossible to escape the ubiquitous idea that some mothers are 'good', others 'bad', and that some mothering practices are 'right' and others 'wrong'. These ideas about mothers pervade our lives. Texts, images, interpersonal interactions, codes, and laws all drench us in messages about what constitutes good and bad mothering and who the good and bad mothers are" (1998:1). Engagement with health professionals during the antenatal period is informed by and informs such notions. Trust is placed in those perceived to be the experts (Giddens, 1991) and their perceptions of 'normal' preparation which is at times contradictory, based on ideas of risk, safety *and* nature. Knowledge claims then are not perceived as competing during the antenatal phase and narratives are constructed in ways which confirm engagement with, rather than resistance to, expert knowledge.

It is the birth which provides a 'narrative turning point' (Frank, 1995). The lived experience of *being* a mother, in contrast to *anticipating* motherhood throws lives into (temporary) confusion. The narratives produced during the early postnatal interviews contain elements of uncertainty in terms of knowing about mothering, and ontological insecurity in terms of not feeling like a mother. Although it is only in

the final interviews that the 'struggles over narration' (Somers, 1994) which were being experienced were fully revealed. It is also during these interviews that the differing professional and personal time frames become most apparent. Whilst many of the women felt, in retrospect, that they had not been properly prepared by the experts for the actual event of birth, there remained an expectation that they would continue to be guided by those perceived to have expert knowledge. In contrast, professional health practise following childbirth involves a limited number of home visits. The number of postnatal visits is linked to professional perceptions of coping and 'normal' transition. It is interesting that most mothers spoke of wanting more visits from the midwives or health visitors, but felt unable to voice this need because they were fearful of the ways in which this might be interpreted. Presentation of self as a coping and competent mother then was an overriding concern.

The competing time frames operating around the early postnatal period, and the underlying assumptions on which they are premised, are clearly discernible here. Whilst the midwives and health visitors expect women to 'naturally' and instinctively know how to mother once a baby is born and so begin to disengage, mothers can feel bewildered and baffled by the new world in which they find themselves: clearly there are tensions here. When mothering is found to be different to what had been expected and anticipated - partly because of professional antenatal preparation - difficulties in making sense of transition can occur. The successful taking over and management of antenatal care not only engenders dependency, but fosters expectations of continued engagement postnatally. Yet professional health care is increasingly targeted at those whose transition is perceived to be problematic (Garcia

and Marchant, 1996). Identifying and monitoring those who do not conform to professional notions of normal transition is a prime focus in the postnatal period. *Abnormal* transition can be 'treated' and so eventually 'normalised'. But clearly, to voice any difficulties in such a climate is not easy. As Romito has observed, "mothers still do not dare to admit how burdensome the constraints and difficulties of their condition can be" and so the challenges of *normal* transition remain unvoiced (1997:172). Paradoxically then, the dominant ideologies which surround early motherhood go unchallenged and myths continue to be perpetuated.

Being a 'Real' Mother.

During the early postnatal period women continue to seek expert guidance because they do not yet feel confident in their own mothering abilities. Inextricably linked to these feelings of not knowing about mothering, ontological insecurities were also experienced. As shown in Chapter 5, many women could be seen to struggle to make sense of their shifting sense of self as a new 'mother'. Ontological struggles were presented in profound accounts of the women's interactions in the different locations of the home and the world outside. Concerns over their own ambivalent feelings on becoming mothers and their abilities to present as 'real' mothers in public places led some of the women to restrict their interactions in the public sphere. Whilst difficulties in constructing a recognisable narrative of new mothering could largely be managed within their own homes, the outside world presented greater risks. Interestingly, Mauthner (1995) has identified withdrawal from social networks as a factor in the development of 'postnatal depression' (Mauthner, 1995,1999).

In his recent work on story telling, Plummer explores "the interactions which emerge around storytelling" (1995:20). Taking a symbolic interactionist approach³, Plummer demonstrates the ways in which we can use stories to project particular selves in particular social contexts. Whilst becoming a mother provides new opportunities for presentation of self, the biological fact of becoming a mother and the expectations which exist around mothering combine to locate mothering in a unique position at the interface between the biological and the social. Because becoming a mother involves a biological act, even though the context in which mothering is then experienced is socially located and culturally embedded, being a mother is always more than "playing a part" (Goffman, 1969:28). Presentation of self as a 'real' mother in the public sphere is then a complicated enterprise. The risks involved in not being perceived as a 'good' mother who is able to cope with her baby, in a society where motherhood and family life are all about being a 'moral' person, were felt by some participants to be too great. As Giddens has noted, "how far normal appearances can be carried on in ways consistent with the individual's biographical narrative is of vital importance for feelings of ontological security" (1991:58). Ontological *insecurity* then combined with epistemological struggles. This clearly had implications for the mothers in their social interactions during the early postnatal period.

Whilst acknowledging that going out presented particular problems, the function of narratives produced during the early postnatal interviews was to present as a coping mother. Reference to time was used to frame

³Plummer notes that "sociology has difficulty in sustaining any of its original theorisations for too long" and goes on to note the shifts which have occurred around 'symbolic interactionism', referring to the "wide range of new and emerging positions" loosely informed by 'symbolic interactionism' (Plummer, 1995).

the gradual process of coping and earlier difficult experiences were revealed within the context of *now* coping. Descriptions of experiences of loss of control were narrated in the context of *now* being in control. Participants also invoked their experiences in the workplace, outside the home, to demonstrate a world in which they had previously been competent social actors. For many, the anticipation of returning to work following maternity leave offered the opportunity of finding/regaining a sense of a 'pre-baby' self. It was a world which had been negotiated and was known, in stark contrast to the new world of mothering. It was also a world in which the boundaries were defined, unlike the all encompassing context in which mothering was being experienced. Participants then constructed and presented narratives of appropriate early mothering in which, if personal threads of difficult/unhappy experiences were revealed, more publicly recognisable language was quickly reverted to. The risks involved in producing challenging accounts, or counter narratives (Somers, 1994), which did not resonate with the perceived experiences of others was, in these early weeks, seen to be too great. The ways in which narratives are powerfully, culturally embedded, and the processes by which "cultures provide specific types of plot for adoption by its members in their configurations of self" clearly effects what can be voiced (Polkinghorne, 1988:153). This "pragmatic connection" then and the "consequences of saying a particular story under particular circumstances" shape the context in which narratives can be constructed and presented (Plummer, 1995:172).

Narratives thus provide vehicles for making sense of experiences through which particular selves can be projected. In the early weeks of becoming a mother, participants sought to present recognisable

narratives of mothering experiences and to present themselves as coping mothers. As shown in Chapter 7 however, one participant's experiences of early mothering led to 'depression' and an apparent inability to narrate what she was living through. She opted out of the early postnatal interviews. Frank has previously made the point that "those who are truly living the chaos cannot tell in words. To turn the chaos into a verbal story is to have some reflexive grasp" (1995:98). This participant re-entered the study for the final interviews and produced a powerful narrative, challenging many of the taken for granted assumptions around mothering and arguing that "you've not failed if something has gone wrong" (Linda). But it was only once she had lived through, begun to be able to make sense of, and to order her experiences, that this participant could reflect and produce a coherent and challenging narrative of mothering. In her work on constructing motherhood, Urwin makes the following, similar observation, that "all the first time mothers were far more anxious and exhausted through the first months than they had anticipated. Here the pain came not only from finding it difficult to cope, but from *feeling they were failing in some way*" (emphasis added, 1985:173).

Experiences then are made sense of by revisiting, reworking and reordering them into coherent narratives, which can be voiced. Consequently, the self is never a finished product. As Polkinghorne observes, the self "is not a static thing nor a substance, but a configuring of personal events into a historical unity which includes not only what one has been but also anticipation's of what one will be" (1988:150). Whilst the biological act of giving birth simultaneously leads to a redefinition of women as mothers, the self as mother is not static, but fluid, partial and dynamic. Transition then is ongoing. As Plummer

notes, "change is ubiquitous: we are always becoming, never arriving" (1995:20). This point was illustrated in Chapters 5 and 6. A comparison of the narratives produced in the early postnatal interviews (Chapter 5) where some of the participants described themselves as feeling like mothers. In contrast, in the later postnatal interviews (Chapter 6), these same participants revealed that at nine months postnatally they mostly did *not* feel like 'mothers'. Dimensions of ontological insecurities could be voiced at this time, challenging fixed notions of 'normal' transition. The ambiguities and complexities, 'the fragmentations and the coherences of self' (Stanley, 1993: 207), become clear as narratives over time are explored.

In the final postnatal interviews the function of the narratives had changed. Shifts in epistemological and ontological security, together with the passing of time over which to reflect, led to more challenging narratives being voiced. The women had become the experts on their own children and, on occasions, could be seen to challenge what they had previously regarded as expert knowledge. Interaction with health professionals, if it occurred at all, was now limited to infrequent clinic visits to have babies weighed, and/or for immunisations. The women were no longer dependent on the experts and the experts had long ago withdrawn as 'normal' transition was perceived to have been achieved. Epistemological security had implications for the ways in which the women could make sense of their experiences and voice ambivalent feelings around being a mother. 'Survival' to nine months postnatally enabled earlier difficult experiences of transition to be revealed. Personal layers of sometimes hitherto unvoiced experiences were more in evidence in the womens narratives. Movement in and out of the worlds of work and home provided different reference points from

which to make sense of, and narrate, a shifting sense of self. The function of the narratives produced during these final interviews was not just to present as a coping mother, but as a 'good enough' mother within the context of acknowledging the difficulties, and rewards, of being a mother. Again, the elapse of time enabled women to place their experiences in context, and to begin to develop confidence in their own 'mothering voice', "amidst the multitude of voices that occur around mothering" (Ribbens, 1998:24)⁴.

Time then is a crucial factor in terms of both competing lay and professional time frames, and the passage of time enabling 'retrospection' and the making sense of difficult lived experiences (Brookes 1984, cited in Mattingly, 1994). "The complexities and socially constructed character of time" is also highlighted (Stanley and Morgan, 1993:3). The importance of being able to produce and sustain a coherent and recognisable narrative through the early weeks and months of mothering was managed by all but one of the women in the study, although different locations presented different challenges. However the final interviews and end-of-study questionnaires revealed that, for some, the process had been a struggle. The overriding need to produce a recognisable account of early mothering led some participants to not acknowledge difficult and unhappy experiences for fear of not appearing to be a 'good' or coping mother *at that time*. The "fragile nature of the biography which the individual supplies about herself" then becomes clear (Giddens, 1991:54). Collecting narratives of women's experiences of transition *over time* enables a "pragmatic connection" to be made between the social processes through which transition is negotiated, and

⁴Ribbens is not arguing for "a 'true' or authentic voice, that could be heard if only it was not drowned out by others", and believes that any voice she has will be 'socially constructed'.

individual experience. Bringing the two together allows us to see how theory and experience are indeed interwoven. This point is reiterated by The Personal Narratives Group, who note that, "traditional explorations of social dynamics have tended to emphasise either the constraints of social structure or the power of individual agency. Only recently have social theorists begun to undermine this polarity. Our reading of women's personal narratives suggests the need to understand the dynamic interaction between the two" (The Personal Narratives Group, 1989:5).

Adopting a symbolic interactionist approach together with a focus on the ways in which narratives are strategically constructed and presented, provides insight into how individuals negotiate, and make sense of, the social world and how they theorise their experiences. The interplay between presentation of self as a competent social actor with a 'history' (Macintyre, 1981:205), and the ability to produce recognisable /acceptable narratives over time, is clearly demonstrated in the womens' accounts collected during the course of this study. Women attempted to make sense of the changes they were experiencing in relation to other areas of their lives in which they had been competent. Uncertain narrative trajectories were found to have implications for projection of a recognisable self as 'mother' and led some women to restrict their interactions in the public sphere. Similarly, narratives of successful mothering were strategically constructed at times, only to be later withdrawn and/or challenged. Subjective experience then led to the production in some cases of 'counter' narratives being produced in order to accommodate experiences which were different to those that had been anticipated. Confidence in their own mothering abilities through coming to understand their child's needs better than any expert, led to a voicing,

retrospectively, of difficult experiences. Knowledge then was no longer associated with 'science' and professional notions of preparation for childbirth and measurements of 'normal', but rather grounded in different lived experiences. Gathering women's narratives *over time* enables different subjectivities to be explored and attempts made to understand what is going on, to theorise experiences. Thus, the shifts made visible by this approach reveal the ways in which transition to motherhood is socially constructed.

The context then in which women negotiate their journeys into motherhood, and in which mothering is experienced, continues to shift. Whilst Plummer has noted the possibilities of challenges to 'old stories', the 'obdurate grip' of stories around motherhood appears particularly firm (1995:131). Feminists have, over several generations, debated and called for changes in the conditions in which mothering is experienced. Yet it appears that the difficulties of 'telling the hard things about motherhood' (Ross, 1995:398) and the conspiracy of silence which exists around early mothering experiences, remain. Notions of 'normal' and 'natural' transition makes voicing difficult experiences problematic (Mauthner, 1999). Recent proposed changes to government policy also raise questions about the place of mothering in late twentieth century society. The message coming from the government appears to be clear, mothers - especially single mothers - should combine work outside the home with their mothering activities. And whilst many women will welcome the opportunity to work outside the home, those who have a choice and choose not to, may find it hard to defend their full-time mothering and 'jobless' status. These dilemmas lay at the heart of the debates in which feminists have engaged. For "an ideology that places mothering exclusively in the private, emotional realm creates conflicts

for mothers who have to work outside the home" (Glenn et al, 1994:16), *and vice versa*. In such a climate then, 'telling the hard things about motherhood' may become even harder.

The context in which mothering takes place has also shifted as demographic and other changes have translated into mothering occurring in different places and at different times in women's lives. The significance of mothering to women's lives, within the context of greater educational opportunities for (some) women and the resulting shifts in patterns of employment has implications for notions of motherhood. More women are delaying childbearing or choosing not to become mothers. There is an increase in the number of single mothers and others who choose 'non-traditional' ways of living and parenting (McRae, 1999). Contemporary mothering arrangements then are more diverse, yet often remain unrecognised in areas of current 'family' policy and practice. This is apparent in relation to mothers whose mothering challenges stereotypes. In their book Mothering against the Odds, Garcia Coll et al (1998) focus on the experiences of mothers who have found themselves to be marginalised; teen mothers, immigrant mothers, lesbian mothers, homeless mothers, welfare mothers and incarcerated mothers. These 'types' of mothers all represent groups who challenge the "'good' mother narrative (which) attempts to assert uniformity where there is diversity; consensus where there are differing perspectives" (Garcia Coll et al, 1998:12). But the difficulties of making women's different and differing voices either heard, or count, remains. So, whilst feminist and other research has gradually sought to explore the differences and commonalties of contemporary mothering experience (Barclay et al, 1997; Garcia Coll, Surrey and Weingarten, 1998; Phoenix, Woollett and Lloyd, 1991; Glenn, Chang and Forcey, 1994)

notions of motherhood remain largely universal, grounded in assumptions of mothering as biologically determined and 'natural'.

Current Policy and Practice .

The narratives of transition to motherhood collected in this study suggest that the context in which mothering is experienced makes it almost impossible to voice difficult experiences as they are lived. This raises questions about the ways and places in which women's voices are listened to and clearly has implications for both policy and professional practice. Debates on the centrality of reproduction to women's lives have continued amongst feminists and others. Compelling arguments have been put forward concerning the medicalisation of women's lives and, more specifically, attention has focused on the medicalisation of childbearing. Fox and Worts note the 'diverse academic disciplines' from which "critiques of the medical management of labour and delivery (have) developed" and call for a greater focus "on the social context in which women give birth" (1999:327). Challenges to the medicalisation thesis have increasingly been mounted in response to research findings which demonstrate women's collaboration in the medicalisation process (Fox and Worts, 1999; Barclay et al, 1997; Rajan, 1996). Whilst collaboration may indeed be a result of the seduction of medicalisation - that is, that risk is perceived to be reduced if women engage in appropriate, medically based, antenatal preparation - the outcome is that many women accept and expect to be guided and monitored by medical experts when pregnant. A measure of the success of the medicalisation of childbearing is that it has become culturally embedded: most women have come to regard the hospital as the 'natural' place in which to give birth. The medicalisation of the antenatal period then clearly has repercussions for the period following the birth.

Furthermore, whilst women's agency has often been overlooked in critiques of the medicalisation of childbearing, agency is always operationalised within specific contexts and locations. Women's agency during the antenatal period is operationalised within the context of powerful cultural expectations of what 'good' mothers-to-be should do and feel. As shown in Chapters 4 and 5, antenatal preparation can be seen to gradually engender a dependent relationship, based upon engagement with experts and reinforced by the birth experience (Lupton, 1994). As Fox and Worts have observed, "a medicalised birth not only fails to empower the new mother but may also *reinforce* her sense of dependency and inadequacy" (1999:331 emphasis added).

However, following the birth, the mothers' expectations of continued interaction with those perceived to be the experts is not mirrored in professional practice. The message that motherhood is a private responsibility is reinforced by the restricted visits undertaken by midwives and then health visitors in what is defined as the 'postnatal period'. For midwives this represents "a period of not less than ten and not more than twenty-eight days after the end of labour, during which the continued attendance of a midwife upon the mother and baby is requisite" (UKCC 1993; cited in Garcia and Marchant, 1997). The role of the health visitor during the postnatal period is less clearly defined in relation to a specific 'postnatal period'. However new mothers may only be visited once at home by the health visitor. The Health Education publication Birth to Five makes this clear, "your health visitor usually makes her first visit sometime after your baby is ten days old. After that she may only see you at clinics or when you ask to see her. If you're alone or struggling, she may make a point of coming by to see whether you need any help" ('Birth to Five', 1998:124), or she may not.

Midwives then are required by statute to visit mothers in their home, and in practice this usually continues up until the 10th postnatal day (Garcia and Marchant, 1997). Increasingly however visits are made on a selective basis and this practice raises questions about perceptions of 'normal' transition and coping. Visits in turn can come to be perceived as signs of failure by the new mother and the difficulty of voicing a need or requesting a visit become heightened. Professionally based, normative preoccupations with transition to motherhood can lead women to remain silent: needs remain unvoiced in a context where diverse mothering experiences are *uniformly* measured. The tensions which underpin both the context and experiences of childbearing in Western society are then particularly insidious. Women are expected to prepare appropriately for motherhood (the 'good mother' narrative) through engagement with experts - a relationship which can engender dependency. However, following the birth, the message that motherhood is a private, and largely individual, responsibility is soon reinforced through the organisation of professional postnatal practice. However, there may be contradictory implications operating here. For the paradox is that the very act of professional disengagement during the early postnatal period, actually creates a space in which women can begin to, have to, develop their own mothering voice, their own ontological security. The double-edged dimensions and tensions which surround competing maternal and medical perspectives in the postnatal period are then clearly discernible.

Listening to Women's Voices?

The ways in which professional practice is currently organised has contributed to women's reluctance to make public, individual and privately experienced difficulties and which is further compounded by

the powerful ideologies which surround motherhood. Patterns of care in the postnatal period have 'survived from the old lying in period' (Garcia and Marchant, 1997:68) and are largely normatively preoccupied, task based, with an emphasis on routine measures being taken to indicate a 'return to normal'. Practice then is based on outdated notions of contemporary women's lives and fails to recognise diversity. As Garcia and Marchant argue, "the needs of the postnatal mother in the UK have changed from those of 70 years ago, and the care provided and observations made by midwives should reflect this" (1997:64). However recent attempts (Winterton Report, 1992) to promote a more supportive role for the midwifery practitioner through 'continuity of carer', which in theory could have promoted a better relationship and space in which women could feel secure in voicing difficulties, has not been realised⁵. The role of the health visitor in postnatal care has more recently been the focus of debate. In their consultation document Supporting Families (HMSO, 1998), the government has proposed an 'enhanced role' for health visitors. In the Green paper it is claimed that "no one feels they are a bad parent or their family has failed because they take the advice of a health visitor. That is why the government is attracted to the idea of building on the excellent service already provided by health visitors" (1998:1.27/11). Yet it was precisely because of their fear of being perceived as not coping and having failed, that some of the mothers in this study felt unable to request visits from their health visitor who, ironically, had assumed they were coping. The consultation paper also proposes that health visitors and/ or midwives make more visits to first time parents, "a series of visits would enable the midwife or health

⁵A recent newspaper article reported that "midwives are being brought into the NHS from as far a field as Nigeria to plug staff shortages that are said to be depriving up to a third of pregnant women of the *continuity of care* they need" (The Guardian, 31/7/99 emphasis added).

visitor to spot any problems with the early parent/baby relationship or the child's growth or health, which could then be referred to the general practitioner" (1998:1.31/12). Whilst greater *support* and recognition of the difficulties of early mothering is to be welcomed, the emphasis is to be on monitoring 'normal' development.

So, whilst the importance of 'talking and listening to women' (Mauthner, 1997) and the benefits of 'listening visits' (Clement, 1995) has been recognised, professional practice has instead tended to focus on the detection of disease or pathological problems in the postnatal period (Garcia and Marchant, 1997). The government green paper appears to reinforce such an approach. One example of a current widespread detection programme implemented in the postnatal period is the Edinburgh Postnatal Depression Scale (EPDS). This short questionnaire was designed to enable health visitors to detect postnatal depression (see Appendix 1). The guidelines in one Health Region (see Appendix 2) reinforce the structured and standardised approach on which postnatal care is based. Instructions to health visitors are provided in the following extract, "one way of ensuring that questions about mood are asked routinely in a standard manner is to ask the mother to complete a questionnaire" (Oxfordshire Guidelines for Shared Care, 1996:2). For the management of postnatal depression several interventions are suggested and ranked. Following 'regular review', 'social support' and/or 'counselling', 'antidepressants' are recommended, "antidepressants are indicated when biological symptoms are prominent, social factors are few, or *the mother cannot verbalise her distress* and cannot make use of counselling" (1996:4, emphasis added). Given the difficulties of producing acceptable and recognisable narratives of early mothering experiences as shown in this study, this approach needs to be

challenged. Several of the participants in my research expressed their concerns at having 'scored badly' on the EPDS in the early postnatal period. They talked of having 'rigged' their responses for fear of being labelled as depressed, when they were experiencing what they felt were 'normal' difficulties, as Sarah commented "and she [health visitor] did keep trying to tell me that I was postnatally depressed, when I don't think I was...I was in floods of tears continuously...and I think it was just normal". Concern was also expressed by one participant that 'constant' screening for postnatal depression may actually lead to postnatal depression, "I start thinking am I falsely being happy...you start feeling as though am I just like being too much like sort of...am I covering up?" (Lillian). Indeed the increased and rigid use of the EPDS has not gone unchallenged by some practitioners, Barker (1998) for example has argued that "health visitors should be encouraged to use their experience and insight, not pre-determined formulas, to assess the well being of their clients" (1998:305).

Rethinking the Delivery of Care to Childbearing Women.

Proposing changes to policy and practice around childbearing may be seen as colluding with medicalisation rather than challenging it. And of course in some ways it is. However, although the intention of this research was never to produce results from which generalisations could be made, exploring the ways in which women negotiate and narrate their journeys into first time motherhood has led me to some unanticipated conclusions. All the women in this study willingly engaged in medicalised antenatal preparation. They actively sought, and collaborated with experts, who reinforced notions of particular ways of preparing to become a mother. They were sophisticated consumers of pain relief. Yet, whilst the women anticipated and expected that the

regular monitoring and shared responsibility of the antenatal period would continue following the birth, this was not the case. The early postnatal period was a time of confusion and for some, narrative bafflement, as experiences failed to match expectations which, ironically, had been partly formed through engagement with health professionals in the antenatal period. Expert advice was perceived as being needed all the more at this time, but the professionals, working with different measures of normal transition, and differing time frames, began to disengage. However it was, paradoxically, the creation of this space which led women to become more epistemologically and ontologically secure. Nine months after the birth of their babies, women could begin to reflect and make sense of their experiences of becoming mothers. They had become the experts.

The narratives constructed and presented by the participants, although emanating from a small, unrepresentative group of white women, provoke consideration of the ways in which childbearing and motherhood is currently organised and experienced in the UK. Whilst acknowledging the diversity of women's experiences, aspects of the commonalities discernible across narratives raise questions about the ways in which childbearing women's needs are met. The timing and underlying philosophy which guides professional practice warrants scrutiny. There is a need to reconsider the delivery of support to childbearing women in an attempt to synchronise, where possible, professional practice and lived experiences. The *normality* of transition to motherhood often being difficult should be recognised and publicly acknowledged. Women need to be given 'permission'/ enabled to talk about the hard things of mothering. However, it is acknowledged that

this would require more fundamental shifts than those achieved through changes in professional practice.

The emphasis on preparation in the antenatal period engenders the development of a dependent relationship which has implications for the early postnatal period. New mothers can feel disempowered and de-skilled by their early mothering experiences - after all it's not something they have done before - combined with the disengagement of the health professionals. Practical and emotional support should be available in ways that recognise and appreciate the hard work of mothering, without being constrained by professional time frames. Support should underpin practice, rather than guidelines which emphasise detection of 'abnormal' transition, and intervention. This necessitates, not just a semantic shift, but a qualitatively different approach to *supporting* women through transition. The "problem of finding clear objectives for postnatal care" has recently been commented on (Garcia and Marchant, 1997:72), and the need to identify objectives which can accommodate the diversity of women's lives is long overdue. The Government's Green Paper Supporting Families (1998) may eventually lead to strategies which address some of these issues, although much of the rhetoric contained within the current document remains premised on particular types of families⁶. However, a shift away from task orientated care to individual care, determined by women's perception of *their* needs, would appear an appropriate place to start. Such a shift would also help redress the balance of power which currently operates in interactions between professional and childbearing women.

⁶ Whilst *support* to families is to be welcomed, there is also a need for social parenting roles to be openly acknowledged and not just parenting roles based on biological relationships.

In practical terms, and accepting the existence of a "cultural dependence on professional health care" (Oakley, 1979) there is a need to develop different ways of listening to, and hearing, women's voices amongst the multitude of competing narratives which exist around mothering. This would not only require a much less prescriptive approach in terms of when, and how, women are professionally supported through childbearing, but a cultural shift in the ways in which motherhood is currently constructed in our society. Women should be enabled to talk about the rewards *and* difficulties of mothering experiences. Silencing of difficult experiences ironically only leads to myths being perpetuated. It is surely time that the 'obdurate grip' of "the 'good mother' narrative" (Garcia Coll et al, 1998:12) be loosened and further challenged, and the diversity of women's subjective experiences be recognised. Whilst feminists and others have previously critiqued the organisation of maternity care and the ideology of motherhood, the dynamics of change necessitates that review, critique and revision continue. The hope is that at some point, and in some small way, professional practice begins to challenge the ideology in which it is grounded, not perpetuate it. More fundamentally however, the concern should be to shift the focus from 'good enough' mothering, to focus on creating a 'good enough' society in which to mother.

Chapter Ten

Conclusions.

Introduction.

In this thesis I have argued that a focus on the ways in which women construct narratives during transition to motherhood reveal both ontological and epistemological shifts. In this chapter I will go on to argue that my findings provide a significant contribution to a feminist understanding of how the self is re-constructed through a period of significant transition. The backdrop of time, and the moral context in which mothering occurs, were found to be significant factors in determining when and what women can voice about their experiences. The collection and analysis of women's accounts over time and through this period of significant transition, both challenge existing medical discourses and enable critique and revision of existing knowledges to be offered (Griffiths, 1995). The narratives presented in Chapters 4, 5, 6 and 7 show that journeys into first-time motherhood take place within contexts that are historically and culturally specific. Even more importantly they are also morally grounded. Becoming and being a mother is inextricably linked to perceptions of being a moral person, to measuring up to dominant and normative conceptions of 'good' mothering. Clearly the "moral minefield" in which mothering decisions occur can make unanticipated and negative experiences difficult to voice (Murphy, 1999:187). In this final chapter it will be argued that experiences of childbirth and caring for a child lead to shifts in women's sense of self, but that an appeal to a recognisable and acceptable self is maintained - although not always satisfied - throughout transition. Getting 'back to normal' is then all about regaining a particular, recognisable sense of self even in the context of experiences that constitute "epiphanal moments" (Denzin, 1991:55). The epiphanal moments provided by

the unique experience of becoming a mother lead to a reassessment of relationships with those previously perceived to be experts. Women's attitudes towards experts shifted over time as material practices and lived experiences led to changed sense of selves and the production of more challenging narratives. When medical discourses around 'normal' transition to motherhood were found not to resonate with lived experiences, these were challenged. The women eventually positioning themselves as experts, their expertise arrived at through experience.

The substantive findings in this work now need to be considered within the context of a broader theoretical framework and in relation to existing literature, in order that the implicit claim to have produced a distinctive, unique and original contribution to knowledge be made explicit. In order to achieve this, the interrelated areas of motherhood, self, narrative, and time and temporality, will be explored in the following sections of this chapter. But before these areas are returned to it is necessary for me to state the theoretical position from which I have engaged in this research and where I now find myself. The focus on the ways in which women *narrate* their experiences of becoming mothers for the first time would appear to locate me quite firmly within a postmodernist/poststructuralist framework - although I acknowledge that there is little consensus about the meanings of these terms, and that different readings of these positions are possible or indeed inevitable. Similarly, the careful exploration of the ways and circumstances in which women construct individual narratives suggests a move away from any kind of appeal to grand narrative or meta-narrative to a focus on pluralities of experiences, interpretations and meanings (Norris, 2000:28). However, I feel unease with wholeheartedly adopting such a position. This is because I do not find that the material, moral, social, cultural, political and historical contexts in which experiences are lived and shaped are sufficiently taken account of, or

addressed, in postmodernist/poststructuralist approaches to understanding the social world, and particularly a gendered social world. I adhere rather to the notion of a society in transition from late modernity to post-modernity, where my interest in concepts of shifting selves through transition is informed by the principles of symbolic interactionism, and a commitment to the need to take account of "the profound influence of the social in shaping (that) subjectivity over time" (Coole, 1995:124). This position will be further teased out over the next sections.

Motherhood

The review of literature in Chapter one of the thesis focused on aspects of the medicalisation of childbirth and ideologies of motherhood. The argument was advanced that the positioning of reproduction and childbearing at the interface between the biological and the social provided an opportunity for medicalisation and regulation of women's experiences of becoming and being a mother. Similarly, that the medicalisation of childbearing in conjunction with the pervasive ideologies which shape expectations of motherhood could be seen to both powerfully reinforce notions of appropriate ways of preparing for becoming a mother and how a 'good' mother should 'naturally' act. In the context of motherhood being bound up with notions of being a moral person, the potential problems of voicing difficult experiences was commented upon. The paradox of this situation - that is, that new mothers collude in the reproduction of myths around motherhood - was also noted. In this concluding chapter, from a position enabling reflection, it is necessary to re-examine the literature in order to make clear the contribution made by the findings of my study.

Literature emanating from a range of disciplines - sociological, anthropological, psychological and medical - and from differing theoretical

perspectives was explored in Chapter one. The different positions taken by different feminists to explore and explain experiences of motherhood were found to be largely grounded in the competing theories of social constructionism and biological determinism (Glenn, 1994; Hill Collins, 1994; Delphy, 1992; Phoenix and Woollett, 1991). Others had adopted standpoints between these two theoretical positions, for example, Chodorow (1978) used psychoanalytic objects relations theory to demonstrate how being mothered by women transmits and reinforces a pattern of female mothering. The approach I have taken has been concerned to explore the process of gathering women's accounts of mothering over time, thus enabling different subjectivities to be explored. The findings support the arguments that mothering experiences take place in a context which is socially constructed. However from the accounts collected it also becomes clear that there is a need to reconsider and revisit the literature which exists around *childbirth*, to question further the context in which birth takes place.

I have earlier argued that childbearing is one biological event that many women will share, but that birthing and mothering experiences are diverse: this point now requires further scrutiny. In her classic study, Birth in Four Cultures based on work carried out in the 1970's, Brigitte Jordan uses a comparative ethnographic approach to reveal the ways in which childbirth is culturally grounded, biosocially mediated and an interactionally achieved event (1994). Through a cross-cultural comparison of childbirth practices, Jordan notes that there is no known society "where birth is treated, by the people involved in its doing, as a merely physiological function. On the contrary, it is everywhere socially marked and shaped" (1994:3). The comparative approach adopted by Jordan reveals the enormously different cross-cultural understanding and experience of supposedly 'biological' phenomenon. The context then in which notions of a biological model of birth

will be/or are defined and biological discourses developed will be culturally specific, products of the societies in which they are shaped. The system of medicalised care which has developed around reproduction and childbearing in Britain can be seen to have both shaped the expectations, and birth experiences, of the women in this study. The location of childbearing in institutions normally associated with illness - hospitals - and the changes that have occurred in patterns of care around childbearing women and family structures converge to locate childbearing outside the realms of everyday experience. As Oakley (1980) has claimed, women in Britain no longer serve an apprenticeship of motherhood. In our late modern/ post-modern society then women are increasingly dependent on those perceived to have authoritative expert knowledge, to engage with medical discourses which are based on the medicalisation of biological reproduction (Oakley, 1993:84). Yet the narratives produced and explored in this thesis reveal that the lived experience of giving birth, becoming and being a mother enables positions to shift and expert knowledge to be challenged.

The accounts collected during this study confirm the argument put forward by Jordan that birth is "everywhere socially marked and shaped" (1994:3). But analysis of the narratives produced by the women in this study have also revealed the ways in which engagement with different discourses about childbirth shift over time. During the antenatal interviews the women were found to willingly engage with those perceived to be experts and to prepare 'appropriately' (see Chapter 4). The hospital in late modern/post-modern society has become the 'natural' setting in which to give birth. The justification for this however was based on the contradictory assertions that giving birth was a natural, physiological act which a women's body should be able to cope with, and yet there was also a possibility that the birth might need to be medically managed and this necessitated engagement with a

medical model of birth. The women believed that if they followed expert advice their birth would be eased, any inherent risk would be reduced. They were aware that they might need medical guidance, but having followed expert advice they felt they should be able to avoid medical intervention. The following extract from Gillian's interview illustrates the complexities of the context in which childbirth is anticipated,

"And also you don't want to be induced either, I'm sure there's a strong feeling that one, you want to do it yourself naturally and second you have a higher incidence of forceps ... and pethidine...Talking with a very open mind on the matter, yes my instincts say that your body will look after itself ... it might need a little help and that's all. Ehm ... but at the same time if things go wrong I'm quite happy ... I'm going to hospital (name), if things go wrong then ... have an epidural, do this, do that ... then I will. I don't think, 'no, I don't want an epidural' ... in my mind I think 'no, I shall manage'. I might try this TENS thing, and I'm quite happy to have some gas and air, so I feel in control. I don't like the feeling of being out of control, ehm and I'm not happy about having pethidine, I think I'd rather have Tens, or gas and air or if things go badly wrong then I'll have an epidural. ... pethidine, I think that with a lot of people it makes them out of control and I don't like that feeling....I think it's the lack of control for me, I think I might be physically and mentally so well under that I wouldn't be on the planet, whereas with gas and air you can just stop it if you feel you're getting out of control and with epidural although physically you lose a lot of control, mentally you still keep it, in fact probably better because you are not distracted by the pain ... But I don't want to be so pushed over having a natural birth that I shall be terribly disappointed if something goes wrong and I need help. I want to try and keep it very open. (Gillian).

In this extract Gillian weaves an account which encompasses the complexities and contradictions inherent in a model of childbirth which has been medicalised. Engagement with expert advice through antenatal preparation classes promotes a relationship in which women are encouraged to believe in their own abilities to get through the physiological act of birth that, at the same time, might also require some medical intervention. However, during the early postnatal interviews, as women recovered from their experiences of giving birth they began to construct accounts which specifically challenged medical discourses, whilst continuing to seek reassurance and support in the early weeks of mothering through engagement with health professionals. In the following extract Felicity describes her experiences of giving birth,

"...awful, it was the most..its the worst thing that I've ever had to go through. I just felt completely violated ...I just can't believe that for somebody who's usually so healthy and doesn't have any tablets, or anything, that I've had all this medication and medical intervention over what's supposed to be a natural event...I thought I'd give birth naturally, quite easily because everybody said you've got childbearing hips...so it's turned out completely wrong for me" (Felicity).

In this extract, Felicity describes her birth experience which has left her feeling "completely violated". Felicity, like many of the women in the study had expected to be able to cope with the physiological aspects of birth, because she had "childbearing hips", because she had prepared appropriately through engagement with those perceived to be experts. The medicalisation of childbirth has led to a shift in the place of birth and the development of routinised antenatal preparation - which is accepted by most women - but discussions around the physical pain of childbirth remain problematic. This is also the case in discussions of pain in childbirth which occur outside formal health care. The sensations of pain experienced in childbirth are difficult to describe. Pain is subjectively experienced and memories of the intensity of the pain of childbirth usually fade quite swiftly in the months following a birth. The experience of giving birth can then be seen to provide both an "epiphanal moment" (Denzin, 1991:55) and a narrative turning point (Franks, 1995). Accounts of how women had actually thought their birth might be are retrospectively revealed (see Chapter 5, pages 88-90). The women's perceptions of birth change as a result of the experience of giving birth. In the postnatal interviews women revealed that they had thought their body's would be able to 'naturally' cope with giving birth. At the same time aspects of the medical model of childbearing begin to be challenged as the women reflect and conclude that they had been inadequately prepared for the realities of giving birth.

In this thesis I have also argued that the contexts in which women live their lives as mothers are socially constructed, historically specific and culturally

varied. Invoking the work of Patricia Hill Collins (1994) it has also been noted that women's experiences of childbearing and motherhood will be diverse and fragmented: mediated by sociocultural factors such as class and race¹. The importance of class and race in relation to women's engagement or rejection of scientific or medical discourses will now be considered. In her work, which emanates from an anthropological tradition, Emily Martin (1990) has focused on aspects of class and race in relation to the ways in which women engage with, or reject, scientific discourses about their bodies. Martin's work is used here to emphasise the important differences that might be expected in the narratives produced by women of different social classes. In my study the sample of women were white and defined themselves as (predominately) middle class. Martin's work suggests that this group of women will engage with medical and scientific discourses, whilst "working-class women" may reject such discourses (1990:79). In her work, Martin considers the ways in which women use medical discourses to explain menstruation. She found that middle class American women's explanations of menstruation "incline toward the medical view" whilst, in stark contrast, "all other working class women interviewed, black and white - share an absolute reluctance to give the medical view of menstruation" (1990:78). Martin considers her findings within the context of differing "material forces in society" and argues that whilst agreeing "that science should not be privileged as a description of 'reality', (but) this does not mean that the discourse of science (indeed any discourse) may not in fact be *socially* privileged by its relation to structures of power" (1990:79). I am arguing here that whilst the white, middle class women in my study willingly engaged with medical

¹It should be noted that motherhood may also be entered into and experienced in ways which do not involve the physiological act of giving birth, for example through adoption. However the arguments developed in this thesis arise from a study of journeys into motherhood which *do* involve the act of preparing and giving birth.

(scientific) discourses antenatally, which were indeed regarded as 'socially privileged' in relation to information from friends and families, the *experience* of birth and becoming a mother - which was not as they had been led to believe - led them to gradually reassess and reject discourses which were not grounded in experience. Following the birth of their child then, they could begin to account for their differing experiences, phenomenologically. Over time, discourses which may previously have been regarded as socially privileged, and incorporated into narrative accounts of preparing to be a mother are challenged, collapsed and/or rejected. Giving birth had usually been much more painful and frightening than the women felt they had been prepared for through their engagement with the medical discourse of childbirth. The attempt then to tease out the discourses around childbearing and motherhood, to explore the context in which women construct particular narratives in particular circumstances or indeed remain silent, raises questions about the ways in which 'selves' are conceptualised and self / identity re/defined over time.

Theorising the Self

Invoking the germinal work of Goffman, I argued in Chapter 9 that "being a mother is always more than playing a part" (p.177). It is now necessary to explore further the grounds on which I am making this claim, to make explicit the ways in which I am theorising the self, and the contribution to knowledge made by my study. So far in this thesis I have implied that the self changes partly through the impact of external events and partly through things going on within the self. Put in these terms, I recognise that I am in danger of being seen to appeal to the idea of a core self, an "essential self" that is rooted in notions of rational choice and a contemporary liberal position (Coole, 1995:124). Questions of the self, however, are much more complicated than this. In the following section I will set out the theoretical position I have

taken in relation to the ongoing debates in the literature and within the context of the accounts collected in this study.

In Chapter 9 of the thesis I acknowledged that theoretical positions within the discipline of sociology shift over time and develop, illustrating the point with a comment from Ken Plummer who has claimed that "sociology has difficulty in sustaining any of its original theorisations for too long" (1995). Plummer illustrates his claim with reference to the "wide range of new and emerging positions" loosely informed by symbolic interactionism (1995). My own theoretical position - further refined as a result of my research - is also informed by symbolic interactionism and leaves me, as earlier noted, unable to fully adopt a postmodernist or poststructuralist position. I locate myself somewhere between these theoretical perspectives because of what proponents from these positions both offer, and omit, in relation to theories of self. The death of the subject in postmodernism and post-structuralism and the reduction of everything to acting in symbolic interactionism (Craib, 1992) are two major concerns to note at the outset.

The intellectual roots of symbolic interactionism can be seen to have originated in the concept of self proposed and developed by George Herbert Mead (1934). In his classic work, Mind, Self and Society (1934) Mead argued that the mind and self were not pre-existent, but emerged through language, "the self is something which has a development; it is not initially there, at birth, but arises in the process of social experience and activity, that is, develops in the given individual as a result of his (sic) relations to the process as a whole" (1934:135). Society was seen as being organised around the individual's abilities to take on the role of the other and individual experiences provided the context in which the individual's self and self-consciousness were developed. Understanding the relationship between self and society in terms of how symbolic communications between individuals

take place formed the basis of Mead's symbolic interactionism. In contrast to more recent interpretations (Goffman, 1969; Plummer, 1995) Mead's development of the concept of self was premised on the belief that society had an objective existence.

In his major contribution to the study of social interaction Goffman - who has been described as adopting a position "halfway between the Chicago School approach, and the more systematic form of role theory" (Craib, 1992:89) - further develops the idea of the self as a social product. A detailed analysis of social interactions enabled Goffman to reveal the ways in which the self is socially constructed. As Lemert comments, "he defines the dramatic techniques and social processes which produce the self and describes the nature of ritual order and the games played to maintain and manipulate it" (1997:1iii). Goffman's theory of the self as a social product is at times however confused by "contradictory sets of definitions" (Branaman, 1996:1vii) and "dualistic images of the self" (Branaman, 1996:1viii). Yet it is these contradictions that for me encapsulate the tensions that arise in relation to a shifting self/sense of self through transition. In his highly acclaimed work The Presentation of Self in Everyday Life (1969) Goffman reveals the ways in which, through impression management, we are able to present a particular self in particular settings, and the ways in which we are able to manage performances. In this work Goffman draws attention to the "all-too-human" task of staging a performance and concludes that the self "is a *product* of a scene that comes off, and is not a *cause* of it" (1969:245). However another reading of this work is provided by Branaman (1996) who argues that a duality of self is implicit in this work when Goffman draws a distinction between an "all-too-human self" and a "socialised self". Branaman comments that "the all-to-human self is the human being as a psychobiological organism with impulses, moods and variable energies, but also is the self which engages

in the all-too-human task of staging a performance" (1996:xlviii). It is the self then as performer who might not be "entirely determined by social contingencies" (1996:xlvi). It is the dualities perceptible in the self as proposed by Goffman that informs my interpretation of the versions of self which are apparent in the accounts provided by the women in the study. In contrast to Goffman's claim that "our activity, then, is largely concerned with moral matters, but as performers we do not have a moral concern with them" (1969:243), I am arguing that the context in which women give birth and become mothers *is* morally underpinned and that this has crucial implications for both a sense of self and presentation of self as a mother. I earlier claimed that "being a mother is always more than playing a part" and the extracts from accounts in Chapter 5 of this thesis illustrate this claim. Whilst women in this study had all the "props" (Goffman, 1969) apparently necessary to be able to give a convincing performance as a mother - a baby, pram etc. - at times they claimed that they did not *feel* like a mother and were concerned they would be found out. This worry was deeply rooted in perceptions of the moral context in which mothering occurs, and not concerns with impression management. The moral dimensions of mothering in our society then can be seen to have profound implications for maintenance of a sense of self.

The more recent contribution to debates on the self by feminist writers is of course relevant here. Debates within feminist theorising of the self has shifted over time from earlier assumptions of a 'core' self to a more recent focus on the self as tenuous, changing and fragmented. In her book Feminisms and the Self Griffiths (1995) usefully encapsulates this shift and notes that "making the subjective experience intelligible helps in 'finding oneself' - a phrase now understood as meaning 'finding a self which is acceptable to itself', rather than finding a real, core self" (1995:77). The gendered self has also become a focus within feminist debates. As Coole (1995) has commented, "the question

of the self has always been central to feminism since in our society we are never simply selves, but gendered selves" (1995:123). The notion of a clearly gendered self, which draws on the differences in bodily matters between men and women is developed by Almond (1988). Almond "argues that the physical facts of menstruation, conception, pregnancy, childbirth and menopause generate a series of moral problems related to identity and self concept for women which are different to those experienced by men who do not go through such changes" (cited in Griffiths, 1995:78). It is these 'moral problems' which underscore my earlier argument that being a mother is always more than playing a part, and which lead me to distance myself from adopting a post-structuralist or Foucauldian position. This is because the gendered self is not simply constituted through "modern discourses and disciplinary techniques" (Coole, 1995), but rather in the context of particular social, moral, political and material circumstances and embodied activities, all of which clearly have implications for the ways in which agency is/can be operationalised. For the women in this study becoming and being a mother can be seen to have challenged perceptions of a sense of self.

The performative nature of self is emphasised in Goffman's work and partly echoed in the women's accounts in this study, especially in relation to presentation of self as a mother in different public and private spheres. However, their 'performances' were grounded in an underlying sense of self which encompassed emotions and feelings and perceptions of particular ways of being in particular circumstances. Transition to first time motherhood provided a context in which these perceptions were challenged and selves re-evaluated. The focus of the study, journeys into first time motherhood, has provided an opportunity to make links between a concept of self as both recognisable *and* shifting. This does not mean that I am appealing to the idea of an essential self, but rather I am arguing that a sense of self emanates from

a recognisable and acceptable self. The accounts of transition collected together in this thesis show the ways in which narrative identities are constructed in relation to a sense of a pre-existent self. The "epiphanal moments" (Denzin, 1991:55) of transition to motherhood leads, over time, to the incorporation of changes to a pre-existent sense of self. In the accounts collected during the antenatal interviews the women's sense of self is bound up with being working women in control of their lives². Motherhood for most of the women is planned and they present accounts of themselves as preparing appropriately. In the interviews carried out in the early postnatal period (Chapter 5) not only has a sense of self been challenged by becoming a mother, but the physical demands of mothering and the (temporary) inability to make connections with their sense of a pre-baby self reveals the frailties and fragmentations of self. By the time of the late postnatal interviews a sense of a pre-baby self, a recognisable and acceptable self has been regained - "I found I was feeling a bit more like my old self again" (Philippa). The women feel that they have regained some control over their lives and one factor in this is their changed relationship with their child, they have come to know their child and patterns of caring are now more predictable. I am arguing then that although a sense of self shifts over time and has different dimensions, there is still an appeal to a sense of self which is recognisable and acceptable, a self which is connected to past events and which is experienced in relation to others.

²Whilst the women in this study were white, employed and predominately middle class, it should be reiterated that for other women, opportunities and experiences will be compounded by their class location. In this context, work and employment will be differently perceived and its relationship to self and identity during transition to motherhood, differently construed and experienced.

Yet of importance here is the context in which a sense of self as an individual and as a mother is constructed. As earlier noted the self is always gendered and experienced within the profound influences of the social world, which shapes subjectivity over time. The moral dimensions of mothering, caring and child rearing shape the cultural context in which mothering is experienced. The context in which subjectivities of mothering are experienced - although diverse - clearly have consequences for women of being 'themselves', or expressing a sense of self at different times in their journeys of transition. Commenting on the actuality of choices in a life and the ways in which these are linked to identity, Benhabib (1992) poses the question, "how does this finite embodied creature constitute into a coherent narrative those episodes of choice and limitation, agency and suffering, initiative and dependence?" (1992:161). Not feeling like a mother, not feeling in control, not recognising the shape of their changed lives, not experiencing a sense of self they recognise, all clearly have implications for the ways in which coherent or recognisable narratives of transition can be constructed and voiced. Yet the importance of 'epiphanal moments' of experience in underpinning re/workings of self must also be noted. Becoming a mother is just such an epiphanous turning point, both throwing lives into temporary confusion and eventually offering the possibility of reworking a changed self, contingent on notions of a pre-baby sense of self. The extract below from Phillipa illustrates this,

"But now I have more of a ... I feel I have more balance, I mean it's affected me ... I think it's changed my outlook. It certainly has changed my kind of confidence, I am probably more confident than I was before actually as a result of having ... because I sort of feel I've ... I've sort of done relatively well you know so I mean although it's really early days but sort of thing she's obviously thriving and ... and I sort of feel a bit more ... probably a bit more balanced rather than ... but I certainly kind of have the same sense of my own identity ... I mean probably ... I don't know really...which is one of the reasons why I wanted to do something outside the home, definitely, I felt I needed that space and time, well not really space because it's ... it's just filled with something else, but I need that time away, away from her, some of the time, and I just ... so I think work has got a lot to do with it, but because I'm doing the two things now, it's probably kind of made me feel more ... in a sense it hasn't actually made me ... given me a split identity at all actually, it's just kind of made the whole thing a bit more whole, a bit more ... in a good way, I feel quite genuinely positive about it" (Phillippa).

The ways in which individuals make sense of a changing sense of self and construct and present a recognisable and acceptable sense of self lead us to consider how accounts through transition are constructed. The apparently overriding concern to present a coherent and culturally recognisable narrative of becoming and being a mother will be further explored in the next section.

Narrative

I have suggested in this thesis that narratives can be seen as a device (one particular kind of device) through which individuals make sense of experiences. It is important however to place narratives within the wider focus of work on 'lives' which can be referred to under the umbrella term of 'auto/biography'. My use of narrative has been clearly informed by previous work around illness which employed the concept of narrative to explore aspects of biographical disruption. I have earlier justified my approach in terms of the medicalisation of childbearing, its consequent location within an illness setting and an awareness that a disjunction between expectations and experiences had previously been documented in the literature on transition to motherhood (see Chapters 1 and 2). However I have also used the concept of narrative in a way that is certainly more structured than some approaches outside the sphere of medical sociology. I have also been in a powerful position as a researcher to elicit, organise and 'truncate' narratives as they are re/presented in this thesis (see Chapter 7). I will return to these points, but first will specify the relationship - and differences - between 'narratives' and 'stories' in my work.

I have earlier argued that although different disciplines have debated the 'nature and significance of narrative', there is consensus that "all forms of narrative share the fundamental interest in making sense of experience, the interest in constructing and communicating meaning" (Chase, 1995:1). Whilst

I have not attempted to gather life stories, I have been interested in exploring how women make sense of their experiences of becoming mothers within the framework of particular social, cultural and moral contexts. A focus on women becoming mothers offered the opportunity of exploring the ways in which experiences are made sense of around an epiphanal event - giving birth and becoming a mother. The interpretation of narrative that I have embraced is then a narrow interpretation, based on its employment within medical sociology (see Chapter 2). This approach clearly differs from a life history approach in which open-ended questions are used to elicit accounts of a life. In the approach I have taken, I have used narrative to explore *episodes* in a life around an epiphanal experience, to reveal the mechanics of how selves are constructed and presented in particular ways at particular times. By taking this approach I have made a distinction between narratives and stories which needs to be explored further.

The terms 'narratives' and 'stories' are increasingly being employed and used interchangeably, within the genre of exploring individual experiences in disciplines within the social sciences. The distinction I have drawn around the terms is linked to my specific focus on the ways in which individual narratives are constructed around a particular event. In his work on Anthropological and Epidemiological Narratives of Prevention, Frankenberg (1989) offers a definition of narrative "as having three distinct meanings (Genette, 1980; 1988): the *narrative* proper, a discourse that undertakes to tell of an event or a series of events; the *story*, a succession of events that are the subject of this discourse; and the *narrating*, the act of enunciating the narrative" (1989:228). In Chapter 2 of the thesis I note that "narratives (then) exist both internally and externally - they are the individual stories emanating from personal experience (and being reinterpreted/ reconstructed over time and in different contexts) and also the collective 'stories' of discernible groups in wider

society" (p.29). Yet in presenting the participants' accounts I move to a position where 'narrative layers' are identified and presented as arising from individuals accounts. These layers are of course related to stories in that they arise from the subject of a discourse, from the stories that we construct and tell. However, I have used the term 'narrative layers' rather than 'story layers' to semantically emphasise the ways in which subjective experiences are linked to a sense of self, and in order to reveal the temporal ordering of experiences around a particular event. Over the course of three interviews, accounts were developed, built on, elaborated or changed. The narrative threads which emerged were woven to produce a particular account of becoming and being a mother. The term 'story' does not, for me, capture the longitudinal dimensions of producing accounts over a long period of transition, nor the mechanisms employed by individuals to present a particular self. Narratives then encapsulate more than description, whilst the inference of the term 'story' can be just that.

The approach I have taken has been informed by Somers (1994), amongst others, who has identified four dimensions of narrativity: ontological, public, meta and conceptual. Ontological narratives, Somers claims, are those used by social actors to define who they are; they are individually held narratives, although resulting from interaction with others. My particular focus on narrative layers arises from my interest in the different types of language, or appeals to different discourses, that are employed by participants to reveal (or conceal) aspects of their experiences. The ways in which narrative layers were combined to present coherent and recognisable accounts of individual experiences, through transition, has been the focus of my research. Taking this particular approach revealed the ways in which "individuals react to pressures to conform to dominant social narratives which are available to

them" (Andrews et al, 2000:1). For example, experiences which had been difficult or different to expectations, were only retrospectively voiced.

The ways in which I have interpreted and used narrative raises further questions which need to be addressed. For example, in what ways has the adaptation and use of an interview schedule previously used in cancer identity work (Mathieson and Stam, 1995) shaped the research?. Also on what grounds am I claiming that the materials gathered in interviews constitute narratives?. These questions are linked to concerns expressed recently by Andrews (2000) who asks, "what are the implications of questions of accountability when we, as sociologists and psychologists narrate the narrations of others?" (2000:3). All these questions are linked by my assertion that researchers construct, to varying degrees, the context in which narratives are produced. Earlier (see Chapter 3) I noted that there has been a shift away from a pretence of 'value-free objectivity' in qualitative research and that this had necessitated transparency and rigour in the ways in which research was carried out. I acknowledge that my decision to use a semi-structured interview schedule incorporating elements of an existing interview schedule (Mathieson and Stam, 1995) will clearly have had implications for the ways in which accounts were structured during the interviews. This approach was decided upon within the context of the research emanating out of medical sociology, informed by both relevant literature (see Chapter 1) and personal experiences (see Chapter 3). My awareness that experiences of becoming a mother appeared to have implications for self and identity led to my inclusion of aspects of Mathieson and Stams' interview schedule into the schedule I was developing. However, the interview schedule finally used in my research was used as a guide during the interviews and not rigidly adhered to, and whilst some participants seemed to find reassurance that I had a sheet of 'questions'

(i.e. was a 'proper' researcher) especially in the first interviews, others narrated their experiences with little encouragement.

The ways in which interviews are structured and the relationship between participant and researcher has increasingly been explored in recent years. For example, Plummer (1995) has described the researcher as a 'coaxer' of stories and Corradi (1991) has written of the active co-production that characterises qualitative interviews. Manzo, Blonder and Burns (1995) have also commented on the relationship between 'tellers' and 'hearers' of narratives, arguing that whilst "tellers of personal narratives furnish those narratives; hearers play an important role in storytelling, but not (typically) in providing the content of the narratives" (1995:308). I would argue that by using a semi-structured interview schedule in research which, outside medical sociology (and sometimes within), is often unstructured, I can be seen to have 'coaxed' participants in a particular way. Indeed Mathieson and Stam (1995) make just this point when they note the context in which their participants accounts are collected and presented: "Conversations with cancer patients are presented in the form of completed narratives yet these narratives were created by the circumstances and structures of a 'research interview'" (1995:284). However, I make the claim to have gathered women's narratives of transition - even though the research was designed around a semi-structured interview schedule - on the following grounds. Almost all research is structured in some way, however loosely, whether from ideas emanating from a literature review, researchers' own experiences, directives from a grant-awarding body, etc. Research does not take place in a vacuum. I would argue then that whilst imposing a structure on a set of interviews clearly sets the scene in a way that otherwise might not have occurred, participants are not without agency and, as noted earlier, researchers 'don't typically provide the *content* of narratives'. However, it is because I claim to have gathered 'narrative trajectories' and not

just qualitative data, that I have set out the above arguments. In short, whilst I recognise that within interviews "conversations are not always narratives, they are frequently the product of momentary, practical realities of daily life" (Mathieson and Stam, 1995:284), I am arguing that narratives are discernible in those aspects of the data which seeks to present a particular story, to position the teller in a particular way. As Mathieson and Stam have commented, conversations "become narratives...when they are part of the quest for personal identity. Of the many stories we tell it is those which are ours, not only about us but by us, that have the most meaning to who we are, where we have been and where we intend to go" (1995:284). Exploring women's experiences of transition to motherhood over the course of three interviews enabled narrative trajectories to be gathered.

It is also interesting to note that the shifts in a sense of self and the appeal to different types of discourse discernible over the course of the three interviews, revealed the ways in which - over and above the research design - some experiences can be voiced whilst others remain unvoiced. Crucially, I am arguing that the moral context in which mothering takes place in our society makes it very difficult to voice experiences which do not resonate with expectations or experiences that appear to differ from perceptions of what is 'normal' transition to motherhood. So deeply rooted are constructions of normal transition and notions of what we can and cannot say in relation to our young, dependent children (see extract on page 124), the risk of revealing difficult experiences can appear too great. It was only retrospectively that difficulties could be revealed and voiced, that counter narratives could be constructed and medical and other discourses challenged. Indeed although I have focused on the layers within narratives, distinct types of narratives of the transition were identifiable. During the antenatal interviews the women constructed narratives of 'appropriate preparation'.

They engaged with medical discourses around reproduction and childbearing, sought and accepted guidance from the health professionals who were regarded as having expert knowledge. In the early postnatal interviews 'coping mother' narratives were produced, although later interviews and some of the questionnaires revealed the struggles behind this particular presentation of self. In the final, late postnatal interviews, narratives of 'good enough mothering' were constructed and presented. From a position of ontological security, epistemological claims of health professionals could be challenged. A shift in sense of self to a recognisable and acceptable self, one dimension of which was being a *good enough* mother, provided a foundation from which to challenge other versions of normal transition to motherhood. The competing understandings of 'normal' transition and different time frames in which these occur will be discussed more fully later in the Chapter.

The identification of different types of narrative at different points in time could be seen to indicate that the research instrument was indeed responsible for influencing the narratives produced. However, I would argue that the moral context in which childbearing and motherhood is experienced is far more powerful and pervasive than any semi - structured interview schedule, in terms of its shaping powers. The fact I was already a mother of more than one child, who was working *and coping* will almost certainly have influenced the ways in which accounts of preparation to become a mother were told in the first interviews. But the comments in the final interviews together with those written by some participants on the end-of-study questionnaire suggest that whilst my research did of course prompt them to reflect on their lives and experiences in ways which they otherwise might not have done (this is discussed in Chapter 8, see for example extracts on pages 159-160), they also felt they had been given an opportunity to voice certain experiences which might otherwise have remained unvoiced. The following lengthy extract is

taken from an end-of-study questionnaire and included because it illuminates some of the points discussed in this section:

I was extremely keen to participate in the study from the outset [*participant accessed through snowballing*]. I had always wondered how data for such research projects was obtained (and from whom) and now I was about to find out! I felt a bit apprehensive prior to the initial interview and worried that I wouldn't be able to provide the 'right' answers. However my fears were soon dispelled when I met the researcher and realised that the interviews were to be conducted in the form of an informal chat and, more importantly, she did not expect model answers, only *my* answers.

The interviews themselves were extremely adept at making me consider certain issues and feelings which I might otherwise have dismissed. It was also fascinating to look back at the way in which I had responded in previous interviews and then to consider my changing views and feelings. It also helped me to rationalise my otherwise irrational thought process!! I think the interviews were timed to perfection, possibly because the researcher was herself a mother and therefore understood the amazing swing of emotions during that very short period and of course the complete memory lapse that occurs in relation to LBB (life before baby) once you have accepted that the life you are now living is yours (not someone else's), and that the baby is here to stay!!

In conclusion, I found the experience [*of being a participant in the research*] positive and rewarding and I look forward to reading the results in due course. (italics are researchers additions).

I am arguing then that whilst broadly similar narratives can be identified across the accounts collected, it is the complexities and contradictions within and across accounts which are of greater significance in this work. It is the ways in which women *strategically* construct narratives in order to present a particular self, at different points through transition, which has been of greatest interest in this study. The paradox however has been that whilst the participants *eventually* feel able to voice previous difficult experiences, and a wider, collective discourse about the 'normal' difficulties of becoming a mother emerges, the medical discourse continues to remain dominant during the antenatal and early postnatal period.

So, what is it then that we are doing when we "narrate the narrations of others" (Andrews, 2000:3) and "whose life is it that is being narrated?" (Mathieson and Stam 1995:302). Clearly, as researchers we are in positions which are potentially powerful. I note in Chapter 7 that having collected data,

decisions were made about the ways in which it should be organised and that I had decided to do this around particular periods in transition to motherhood; antenatal, early postnatal and late postnatal. I felt the effect of this was that participants' narratives were truncated and clustered around particular periods, but within the work I was producing this was an appropriate and acceptable way to proceed. But this decision illustrates both the power of the researcher and underscores the point that in taking a narrative approach we are always presenting or narrating the narrations of others, their narrations are filtered through us (in the interview), and by us (when presented in written accounts). Ultimately, by placing such accounts in the public, academic sphere, we are ourselves contributing to what Young describes as "the narrativity of social scientific discourse" (1989:154).

Time and Temporality

In this thesis I have argued that the epiphanal experience of becoming a mother presents a challenging context in which to produce narrative accounts and construct a narrative identity. I have also emphasised the importance of temporal ordering in constructing recognisable (culturally embedded) and coherent narratives through transition to motherhood and noted that the specific transitions with which I am concerned take place over time. The choice of a longitudinal format implies that time and temporality are a crucial aspect of experience. The longitudinal research design emphasises both personal transition and passages of time. Shifts in a sense of self occur through time and the passage of time enables reflection. However the complexities of time and temporality need to be further interrogated rather than 'taken for granted'. As Adams observes, "there is no single time, only a multitude of times which interpenetrate and permeate our daily lives. Most of these times are implicit, taken for granted, and seldom brought into relation with each other: the times of consciousness, memory and anticipation are

rarely discussed with reference to situations dominated by schedules and deadlines" (1995:12). In this thesis participants' accounts have been organised around linear time, the data presented chronologically to mirror stages in transition. Yet the timing of the interviews was decided upon in relation to stages within transition to motherhood emanating from, and identified by, medical discourses and not in relation to other notions of time, for example "body time" (Adams, 1995:43). Clearly, I have set the research within a particular understanding of time, one which is culturally grounded and 'Western' (Gubruim, Holstein and Buckholdt, 1994:34). Similarly, whilst I have drawn attention to competing professional and lay 'time frames' (see Chapter 9) these too are underpinned by notions of time which are crucially different and need to be further unravelled.

In her fascinating book, Timewatch, Barbara Adams highlights "the complexity of body times and its uneasy relationship to the invariable, finite time of the clock" (1995:43). The significance of this, however, has been lost in industrial countries where the medicalisation of childbearing is based on, and guided by, clock time and calendars. As Adams notes, "the process of giving birth...is particularly well suited to theorizing the relation to the surrounding environment of clock time" (1995:47/48). Regimes during antenatal preparation, during labour and birth, and following birth are all measured in terms of "the calendar and the clock" (1995:48). Endogenous body time is only alluded to, for example in establishing intensity of contractions during labour, but regularity of contractions are measured against 'clock time'. And so during birth, "the woman is forced to oscillate between the all-encompassing body time of her labour and the rational framework of her clock-time environment" (1995:49).

The everyday time of clocks and calendars continues to dominate during the postnatal period. Professional assumptions around normal transition are rooted in a framework of finite, rational time which must accommodate routines and measures of development within specified calendar time. Such notions of time are reinforced in numerous ways, through professional practise, child care manuals, measures of a return to 'normal' etc. For women, becoming and being a mother encompasses 'time' in ways that will be experienced as contradictory and at times unhelpful. Yet the complexity of our conception of time is further emphasised by Adams who notes, "even the idea of oscillating between two times - the archetypal and endogenous temporality of the birthing process and the rational clock time of obstetrics - is misleading since those times interpenetrate and mutually inform each other's meanings" (1995:49/50).

Conceptions of time are then culturally grounded and, in western societies, understood through our temporal perceptions of chronology. We experience ourselves and narrate a sense of self through connecting the past, present and future. Narrative and temporality are crucially linked. "Not only do stories have a necessary temporal and sequential dimension in their telling or reading, but they constitute reality and human action as sequential, historical in time. Stories have beginnings and endings" (Del Vecchio Good et al, 1994:856). The focus on narrative construction which has been taken in this thesis has shown that whilst new mothers may be encountering uncertainties in terms of time horizons, they construct and present narratives as 'coping' and 'good mothers' although retrospectively they reveal the uncertainties they had actually been experiencing. From a changed ontological position, they are able to invoke their own experiences to challenge professional measures of normal transition, implicitly to challenge professional notions of time.

However, 'body time' and feeling able to cope were experienced differently and at different times by the new mothers.

I have argued then that competing 'time frames' were discernible between professional notions of normal transition to motherhood and new mothers lived experiences. However, the experiences of the participants were not homogenous and these need to be considered in a more differentiated way. Whilst broad narrative types have been identified, within these - and specifically in relation to time - experiences at different times differed. During the early postnatal period, it was *later* revealed, expectations were not met and early mothering was different to what had been anticipated. In the late postnatal interviews and end-of-study questionnaires, difficulties that had been lived through were retrospectively revealed. In Chapter 6 I juxtapose extracts from some participants early postnatal interviews with those from late postnatal interviews to show how the passage of time, and a shifting sense of self, enables different accounts of transition to be revealed. In particular, Phillipa (p.133) reveals how badly she feels she coped in the early weeks and months - echoing the struggles experienced by most of the women. In contrast however, Peggy surprised herself by how well she had coped (p.97). Clearly these differences have implications for interactions with health professionals. Although the complexities of time have been noted, the early postnatal period is not 'empty time', but time in which a gradual shift from a dependence on other experts, to a position of ontological security occurs. Paradoxically, it is the disengagement of health professionals in the early postnatal period which creates a space, and time, in which ontological security can develop.

Conclusion

This thesis provides a unique contribution to a feminist body of knowledge which seeks to understand how the self is theorised through a period of significant transition. In this thesis I have argued that although a sense of self shifts over time and has different dimensions, there is still an appeal to a sense of self which is recognisable and acceptable, a self which is connected to past events and which is experienced in relation to others. However, the conditions in which we understand and make ourselves is not of our choosing. Individual narratives are constructed in relation to material, moral, cultural, historical and political circumstances. The “epiphanal moments” (Denzin, 1991:55) provided by the unique experience of becoming a mother lead to a reassessment of relationships with those previously perceived to be experts. Women's attitudes towards experts shifted over time as material practices and lived experiences led to changed sense of selves and the production of more challenging narratives. When medical discourses around 'normal' transition to motherhood were found not to resonate with lived experiences, these were challenged. Eventually the women in this study positioned themselves as the experts, their expertise arrived at through experience. This thesis provides an original contribution to knowledge through its particular foci on the ways in which motherhood, narrative, self and time are crucially interrelated around the epiphanal event of women becoming mothers.

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Edinburgh Postnatal Depression Scale

You have recently had a baby, we would like to know how you are feeling. Please tick (✓) the appropriate boxes which come closest to how you have felt in the PAST 7 DAYS, not just how you feel today. Here is an example, we felt happy:

- Yes, all the time ☐
 Yes, most of the time ☒
 No, not very often ☐
 No, not at all ☐

It would mean I have felt happy most of the time during the past week. Please complete the other questions in the same way.

the past 7 days:

I have been able to laugh and see the funny side of things

- As much as I always could ☐
 Not quite so much now ☐
 Definitely not so much now ☐
 Not at all ☐

I have looked forward with enjoyment to things

- As much as I ever did ☐
 Rather less than I used to ☐
 Definitely less than I used to ☐
 Hardly at all ☐

3* I have blamed myself unnecessarily when things went wrong

- Yes, most of the time ☐
 Yes, some of the time ☐
 Not very often ☐
 No, never ☐

4. I have been anxious or worried for no good reason

- No, not at all ☐
 Hardly ever ☐
 Yes, sometimes ☐
 Yes, very often ☐

5* I have felt scared or panicky for no very good reason

- Yes, quit a bit ☐
 Yes, sometimes ☐
 No, not much ☐
 No, not at all ☐

6* Things have been getting on top of me

- Yes, most of the time I haven't been able to cope at all ☐
 Yes, sometimes I haven't been coping as well as usual ☐
 No, most of the time I have coped quite well ☐
 No, I have been coping as well as ever ☐

7* I have been so unhappy that I have had difficulty sleeping

- Yes, most of the time ☐
 Yes, sometimes ☐
 Not very often ☐
 No, not at all ☐

8* I have felt sad or miserable

- Yes, most of the time ☐
 Yes, quite often ☐
 Not very often ☐
 No, not at all ☐

9* I have been so unhappy that I have been crying

- Yes, most of the time ☐
 Yes, quite often ☐
 Only occasionally ☐
 No, never ☐

10* The thought of harming myself has occurred to me

- Yes, quite often ☐
 Sometimes ☐
 Hardly ever ☐
 Never ☐

Source: Cox JL, Holden JM, Sagovsky R. Detection of Postnatal Depression. Development of the 10 item Edinburgh Postnatal Depression Scale.

Br J Psych 1987; 150: 782-786

Oxford Postnatal Depression Strategy



APPENDIX 2.

Oxfordshire Guidelines for Shared Care

Postnatal Depression Guidelines for the Primary Health Care Team

Introduction

About 10% of women experience a depressive illness in the year after delivery of a baby. Postnatal depression (PND) is similar in nature to depression at other times. However, recognition may be obscured by physical factors, a mother's unwillingness to admit difficulties, or cultural barriers to accepting that depression at this time is abnormal and treatable. In addition, there is often lack of confidence amongst health care workers about how to identify and treat such depression.

These guidelines aim to raise awareness of the nature of PND and related disturbances, and outline some management options. The Oxford Postnatal Depression Action Group was set up to improve identification and treatment of postnatal depression. The strategy outlined here is in line with the Defeat Depression campaign and with targets set in *The Health of the Nation*.

Postnatal depression is treatable and early diagnosis and confident management can reduce misery.

The impact of PND is greater than depression at other times. A woman's confidence and her ability to mother her child are reduced, and this may lead to permanent regret and guilt. The relationship with her partner may suffer and some partners themselves also become depressed. The relationship with the child is impaired and children of women with severe PND can show cognitive, behavioural and emotional problems up to the age of 5 years old. This does not occur where a mother becomes depressed when her baby is one year old or later.

A few mothers are depressed enough to warrant specialist treatment, even hospital admission. Most are miserable, but cope. Depression may last a few days or weeks but may be long lasting, and this is more likely if PND is missed. A few women develop chronic patterns of distress, which may emerge in a crisis much later, sometimes as anxiety during the next pregnancy.

Prepared by the Oxfordshire Depression Multi-Disciplinary Group for the file - *Working for Health in Oxfordshire, Guidelines and Protocols*. Extra copies can be obtained from Oxfordshire Health Promotion, Block 10, Churchill Hospital OX3 7LJ. (01865-226046).

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We are grateful to Duphar for sponsoring the printing of these guidelines.

Revised January 1996

1 - Introduction

Oxfordshire Guidelines for Shared Care

Postnatal Depression

Some factors increase vulnerability. Women are more liable to PND if they have:

- ◆ a psychiatric history of affective disorder (especially postnatal problems)
- ◆ a poor marital relationship
- ◆ severe anxiety in pregnancy
- ◆ no confiding relationship
- ◆ adverse social circumstances

Strategy for detection of PND

The strategy will be implemented by making use of routine contacts with pregnant and postpartum mothers. For a diagram of the strategy, see page 7.

Antenatally

Women will receive a leaflet and be offered the opportunity to voice any concerns about their emotional well-being. Midwives will introduce women to the strategy and encourage women to be prepared for emotional changes following the birth. For women from minority ethnic groups, the information leaflet has been modified and translated into five Asian languages: Hindi, Punjabi, Bengali, Urdu and Chinese.

Postnatally

Health visitors in Oxford city are trained in the use of the Edinburgh Postnatal Depression Scale (EPDS).

The Edinburgh Postnatal Depression Scale

One way of ensuring that questions about mood are asked routinely in a standard manner is to ask the mother to complete a questionnaire. The EPDS has been developed as a screening tool for the detection of PND, and validated for use, particularly at 6-8 weeks at the postnatal check. It is also useful later in the postnatal year. The EPDS is to be completed by the mother alone, at routine points of contact with health visitors.

Those scoring highly will be clinically assessed, by expanding on the questions and by exploring the context, the persistence and the severity of symptoms. This assessment will be carried out on a different occasion, usually by the health visitor, or if necessary by the GP. Many women who score highly have a depressive illness. Some have mild, transient low mood. Some have other conditions such as anxiety disorder, physical illness, or social difficulties.

Scoring

| 1-8 | 9-13 | 14-19 | 20+ |
|--------|---------------------|---------------------|--------------------|
| Normal | Possible depression | Probable depression | Severe disturbance |

When given?

Health visitors will offer the scale as part of their routine follow up of mothers at:

- ◆ **First postnatal visit**
The first use is to introduce the idea to the mother that this scale is easy and simple, and to talk about mood disturbances and postnatal depression
- ◆ **6-8 weeks postpartum**
The second screening will detect a large proportion of those who would become depressed in the first year following the birth.
- ◆ **6-8 months postpartum**
The third screening picks up those mothers who developed depression later or who slipped through the net.

It is hoped, that giving pregnant women information about depression and repeating it each time the questionnaire is used will encourage women to present mood problems early, rather than waiting to be screened.

Action following diagnosis

A high score prompts action by the health visitor to confirm the diagnosis with the general practitioner and to initiate counselling treatment where appropriate

| 1-8 | 9-13 | 14-19 | 20+ |
|-----|-----------------------------|---|---------------------------------------|
| Nil | Repeat EPDS in two weeks | Clinical assessment (GP) Health visitor counselling ?+Antidepressants | As for 14-19 ?+Psychiatric opinion |

After eight weeks of counselling, the EPDS should be repeated and a clinical review held of the woman's mental state. Proceed with other clinical options if the depression is unresolved. High scores linked with depression are often associated with the following symptoms and behaviour patterns. Scores of 14+ should always be discussed with the GP, and a clinical assessment should be carried out.

Symptoms

- ◆ Low mood (suicidal ideas),
tearfulness
- ◆ Early morning wakening,
hypersomnia
- ◆ Guilty ideas, self blame,
inadequacy
- ◆ Overwhelming tiredness
lethargy, withdrawal
- ◆ Sleep disturbance (not
due to baby or partner)
- ◆ Appetite disturbance
Over- or under-eating
- ◆ Over-anxiety, obsessional
thoughts
- ◆ Apathy or hostility
towards the baby

Revised January 1996

3 - Action following diagnosis

Oxfordshire Guidelines for Shared Care

Postnatal Depression

Behaviour

- ◆ Repeated presentation of baby with trivial complaints
- ◆ Unexpected failure to attend clinics
- ◆ Obsessional behaviour
- ◆ Alcohol abuse
- ◆ Presentation of mother with multiple somatic complaints
- ◆ Withdrawal, agoraphobia
- ◆ Self harm (overdose, cutting, etc.)
- ◆ Child abuse

In many cases a problem is immediately apparent. Some mothers may “put on a front” for a visit, in which case only specific enquiry will reveal depression.

Management of Postnatal Depression

The following interventions, which are not mutually exclusive, may be considered.

1. Further regular review

For mild or equivocal cases your support and the passage of time may bring resolution, or clarify the need for further action.

2. Social support

The challenges of motherhood can precipitate depression in women without supportive relationships or in adverse social circumstances. Improving these factors will help recovery. Support can be offered by carers formally (practice counsellor, practice nurse, GP,) or informally (friend, relative, vicar, other mothers). A social worker may help to sort finances or housing applications. A health visitor or another mother can introduce a depressed mother to support groups. Relatives can be encouraged to give extra time and practical help. If the mother agrees, relatives can be informed that she has postnatal depression.

3. Counselling

Research has shown that regular non-directive counselling can relieve PND in two thirds of those women who are moderately depressed. In central Oxford health visitors are trained to offer 30 minute sessions once a week for eight weeks, to moderately depressed mothers.

4. Antidepressants

Antidepressants are indicated when biological symptoms are prominent, social factors are few, or the mother cannot verbalise her distress and cannot make use of counselling. Some women prefer them to counselling. Ensure that the antidepressant prescribed does not have side effects that hinder compliance, and is suitable for breastfeeding mothers.

Tricyclic antidepressants

These drugs are highly effective for the treatment of depression. However their use is severely limited by well-known adverse side effects leading to non-compliance. These side effects are dose related so compliance is improved by starting with a low dose and increasing gradually.

Lofepamine is an acceptable tricyclic. It is low in side effects, does not sedate, and can be used safely in breast feeding, and when driving. It is also reasonably safe in pregnancy.

Dose 140-280mg daily

Amitryptiline is a stalwart in the repertoire of psychotropic drugs. Its use, safety, efficacy and side effects are well known. It is useful, especially where sedation and control of agitation are required. Do make sure the woman knows about side effects and that you monitor for compliance. It is safe in pregnancy and breast feeding. It is dangerous in overdose, and impairs driving. If substantial doses are used it may be necessary to get extra practical help at home while mother accommodates to the medication.

Sedative Dose 25mg daily

Antidepressant Dose 75-150mg daily

Other tricyclics are similar to amitryptiline in use though nortryptiline and imipramine are less sedative. Dothiepin has fewer side effects than amitryptiline while improving sleep, but is the most dangerous in overdose.

Selective Serotonin reuptake inhibitors (SSRIs):

SSRIs are new drugs promoted for use in the community because of the simple dose regime and lower side effects. They do not sedate. The immediate side effects are nausea and anorexia. Paroxetine is calming for anxious mothers. Fluoxetine can cause agitation and akathisia, but is better for women who are slowed up by depression. They have not been fully evaluated and their potential in childbearing women is still under review. None can be deemed safe in pregnancy. Fluoxetine is contra-indicated in breastfeeding mothers. Only a small amount passes into breast milk, but with its long half-life fluoxetine can accumulate in the baby. There is no information about sertraline.

Fluvoxamine can be offered to the breastfeeding mother. It has little passage into breast milk. It is not known to be safe in pregnancy. Its main side effects are nausea and anorexia. Paroxetine is probably safe for the lactating mother. Early studies show that only 1% of the dose passes into the milk.

Dose 20-50mg daily

Appendix 3

Women's Experiences of Becoming Mothers: End of Study Questionnaire.

This questionnaire is designed to gather some general details about you and more particularly about your experience of being a participant in this research project. Please complete Section 1 and add extra pages to Section 2 if you wish.

Section 1: General Details

1. Your date of birth

| | | | | | |
|--|--|--|--|--|--|
| | | | | | |
|--|--|--|--|--|--|

2. Age at which you left school _____

3. Educational achievement(s) _____

4. Your occupation (*if applicable*) _____

5. Partners occupation (*if applicable*) _____

6. How many weeks pregnant were you when you started maternity leave? (*if applicable*) _____

7. Have you now returned to work? _____

8. How many weeks/months after the birth did you return to work? _____

9. If asked to describe which social class or group you would place yourself in, which would it be? _____

Section 2: The Research Process

The following section is about your own experiences of being a participant in this study.

10. How would you describe being a participant in this research project? (for example you might like to include your thoughts on the interviews, their regularity, the researcher etc..) *Please continue on a separate sheet if you wish.*

11. If you would like to add anything further, please do so in the space below

Finally, **thankyou** for **your** involvement in the study as without you it would not have been possible. If you would be interested in receiving news of the findings from the study - which won't be until summer 1998 - please tick this box ☐ and add your contact address below.

Appendix 4.

Interview schedule developed by Mathieson and Stam (1995)

Table 2. *Open-ended identity questions*

-
1. Please think back to the 6 months preceding your diagnosis. How would you describe those months?
 2. Describe to me what you recall thinking at the time of the initial diagnosis.
 3. I would like you to summarize the course of your disease for me thus far. For example, can you tell me about your treatment? How would you describe your 'normal week'? Describe to me what will happen in terms of your next course of treatment.
 4. Do you think you have received/are receiving adequate information from health care professionals?
 5. What things are different about your life now than before you had cancer?
 6. How have people responded to your cancer? What have they said, or done, which was helpful, or not helpful? (a) spouse, (b) family, (c) close friends, (d) other friends, (e) co-workers, (f) health care professionals, and/or (g) anyone else? Did any of these things change the way you thought about yourself or about having cancer?
 7. What is different about yourself since your diagnosis? In other words, is the way you see yourself now different from the way you saw yourself in the past?
 8. What is different about your body since your diagnosis?
 9. Since your diagnosis, has your relationship changed with your (a) partner, (b) family/children, and/or (c) friends?
 10. What do you think caused your cancer?
 11. What does the term the 'future' mean to you right now? What are your feelings about your life expectancy?
 12. Do you feel your cancer is/can be cured?
 13. Is there anything that I have failed to ask you in this interview which is important for me to know?
 14. Looking over your whole cancer experience, what is the most significant change in your life that has taken place as a result of the diagnosis?
-

APPENDIX 5.

Areas for consideration in interview.

Experiences and expectations in the antenatal period.

- * I wonder if you could describe to me what you recall thinking at the time you found out you were pregnant?
- * How have you felt being pregnant?
- * Is being pregnant as you'd expected it to be?
- * Did you have any expectations?
- * Where did those expectations come from?
- * What things are different about your life now than before you were pregnant?

(i.e. How is pregnancy 'perceived' and 'described', what terminology is used? medical or phenomenological or other?)

- * Have you tried to find out about pregnancy?
- * Which sources of information have been most useful? (from friends, books, clinics?)
- * Do you think you have received /are receiving adequate information from health care professionals?

(i.e. Does respondent mention 'informal' sources of information e.g.. friends' relatives and/or does she talk of information gained from 'official' sources e.g.. clinics, midwives etc..)

- * How would you describe being pregnant?
- * What things are different about your life now than before you were pregnant?
- * How have you felt during your pregnancy?
- * What have you enjoyed most about being pregnant?
- * What have you enjoyed least about being pregnant?
- * How have 'others' responded to your pregnancy? (e.g. partner, family, friends, work colleagues etc..)
- * What, if anything, is different about yourself since you found you were pregnant? In other words, is the way you see yourself now different from the way you saw yourself in the past?
(Expectations for the future, if any)

- * What does the term 'future' mean to you now? What are your feelings about becoming a Mother?

(If respondent has not mentioned antenatal care, in terms of clinic visits etc., mention this now)

- * Have you any thoughts on the antenatal 'care' you have received?
- * Is there any aspect of being pregnant that you would like to have been different? or would like to change?
- * Looking back over the previous months of your pregnancy, what is the most significant change in your life that has taken place?

(how does respondent describe this ?)

- * Is there anything that I have failed to ask you in this interview which you would wish me to know, or anything you would like to add?

First Postnatal Interview Schedule.

I'd like you to tell me in your own words what's happened since we last met

*Time leading upto the birth.

*The birth.

*Looking back over the antenatal period, how useful was the information you'd acquired?

*Which, or who, on reflection, provided the most useful source of information before your baby was born?

*Since the birth of your baby, have you had contact with the 1) midwives, 2) health visitors 3) G.P.?

*How would you describe their role in this postnatal period?

*Have they been helpful?

*Have you felt you've needed them?

*Have you had your 6 week check? How was it?

*What, or who, has been your greatest source of support since having your baby?

*What things are different about your life now than before you had your baby?

*How have 'others' responded to you since the birth of your baby? (e.g. partner, family, friends, work colleagues etc..)

*What, if anything, is different about yourself since you had your baby? In other words, is the way you see yourself now different from the way you saw yourself in the past?

*What are your feelings on becoming a mother?

*Do you feel like a 'mother'?

*What does the term 'future' mean to you now?

*Looking back over the weeks since the birth of your baby, what is the most significant change in your life that has taken place?

Second Postnatal Interview Schedule.

I'd like you to tell me in your own words what has happened since we last met? (return to work? etc..)

Have you returned to work?

How have you managed that? (child care arrangements etc..)

Who has taken **responsibility** for organising childcare etc..?

Did you want to return to work? (or did you have to return to work for financial reasons?)

Who would you say has been the most helpful source of support ?

Have you had any/much contact with any health professionals? (eg Health Visitors etc...)

Have other family members or friends been sources of support in this period?

Have you felt the **need** for support?

Would you say your life is different now when compared with your life before you became a mother? (in what ways? etc...)

What if anything is different about **yourself** since you had your baby? In other words is the way you see yourself now different from the way you saw yourself in the past? (In terms of identity, feeling like a mother?, identifying with the mother role)

Do you feel like a mother? (what about the experience of juggling mother/ work roles? **Coping?**)

Going back to the time your baby was born, and your **birth experience**, what are your **memories** of it now? (has time dimmed the memory?)

What does the term **future** mean to you now?

Does the future include plans for having more children?

Is there anything I have failed to ask you that you would like to add?

Thanks/ Questionnaire.

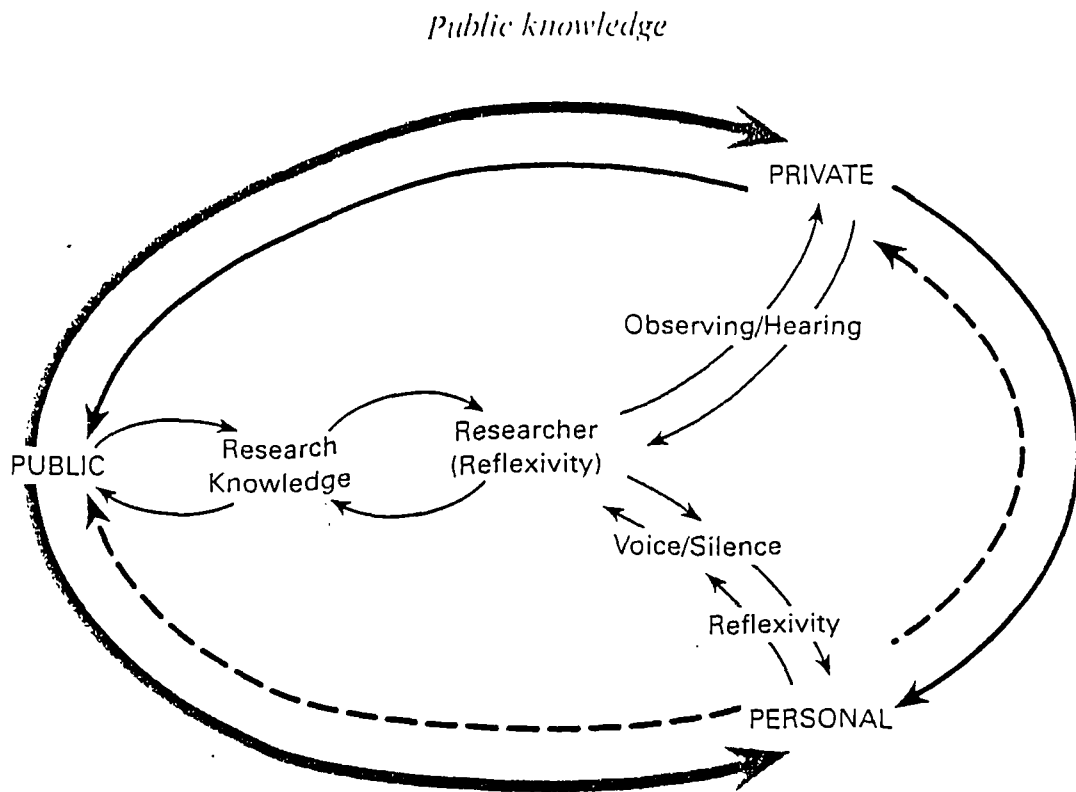


Diagram taken from Ribbens, J. and Edwards, R. (1998) *Feminist Dilemmas in Qualitative Research*. London: Sage.

Bringing in the personal

In working with the concepts of public and private and in editing this book, we have come to recognize the importance of another dimension within this conceptualization – that of the ‘personal’ – and how this is linked to the public and private, and to researching the private in order to make it public. In academic discussion we tend to refer to formal, large-scale organizations (of employment, state, education, etc.) as constituting the public domain, while family, home-centred and informal relationship-centred settings may be described as constituting the private domain. But in their own use of these terms, people may refer to some private settings as ‘public’ in the sense of exposure to a less intimate and trusted audience, or define some settings within the public sphere as ‘private’, and thus distinguish a further ‘layer’ of privacy as personal space.

Figure 1.1 is intended to help clarify some of our thinking on these issues. In our uses of the terms within this diagram, the concepts of both ‘public’ and ‘private’ share the fact that they appertain to *social* lives and social settings, in the sense that they refer directly to interactions between people. The public we have already characterized as more goal-oriented and individualistic in its overt value system, and its way of being and knowing. The private we have characterized as more process-oriented and connected in its value system, and its way of being and knowing. Sites that are ideologically constructed as more public include formal organizations, formalized policies and legal systems. Sites that are ideologically constructed as more private include families, kinship, friendship and social networks, and lay knowledges. But the diagram also incorporates the concept of the ‘personal’, as a way of drawing attention to experiences that are constituted around a sense of self or identity, to do with emotions, intimacy, or the body. We are not suggesting that the personal is not also social, but that it concerns the social as ontologically experienced by the individual; that is, in relation to a person’s own sense of being or existence.⁷

The arrows in the diagram refer to the routes by which paths of influence or domination may occur between these different sites. The arrows may thus refer (among other things) to language, actions, the organization of physical space, images and representations, and orientations to time. Notions of rationality, morality and so on would be expressed via these concrete manifestations. Finally, we have used the diagram to represent the position of the researcher, situated at the interface of the fluid edges between, and the combining of, public, private and personal lives. Before private settings can be represented in public knowledge, they first have to be open to observation, and their ‘voices’ have to be heard by the researcher, and for personal experience to be heard within academic discourse it first has to be voiced within a research interview, or within other types of material collected from participants, such as diaries (see Linda Bell, this volume). The researcher is thus poised on the threshold between these different experiences and social settings.

Angela

Angela was aged 30 years at the time of the first interview (at 36 weeks pregnant). She described her pregnancy as 'planned'. Angela had left school aged 17 years prior to taking a secretarial course. At the time of the pregnancy she was employed as a secretary in a university department. Angela was married and her husband was employed as a production worker. She returned to her secretarial position on a part time basis when her baby son was nearly 4 months old. In the end of study questionnaire she described herself as 'middle class'.

Interviews with Angela

The interviews with Angela were carried out in the University where we were employed, this was her choice. This setting was more formal than the other interviews which were carried out in participant's homes and as the first and third interviews were organised around lunchtimes - time was a constraining factor. The first and third interviews¹ lasted approximately one hour and the early postnatal interview was slightly longer as Angela was on maternity leave at that time and had brought her baby son along with her. Because we had seen each other at work in the preceding years - although did not know each other - and worked in different capacities in the University, I always felt that Angela was slightly uneasy in the interviews. In her end-of-study questionnaire, Angela suggested that more structured approach might have been adopted to gather some of the data. Angela also notes that it was "a bit nerve-wrecking to start with".

Gillian

Gillian was aged 33 years at the time of the first interview (at 33 weeks pregnant). She described the pregnancy as 'planned'. Gillian had left school aged 17 years with nine 'O' levels and trained as a nurse. She was employed as a Nursing Sister at the time of her pregnancy. Gillian was married and her husband was a self employed builder. Following the birth of her baby daughter, Gillian returned to very part-time nursing work once her baby was 9 months old. In the end of study questionnaire Gillian described herself as 'middle class or group B'.

Interviews with Gillian

The interviews with Gillian took place in her home. The antenatal interview lasted for just under one hour during which Gillian plotted a course of preparation which had included health professionals, friends and a belief that her body should be able to cope with the birth. The early postnatal interview lasted 1 hour and 15 minutes and the final interview just under 1 hour. All the interviews were relaxed and in the end-of-study questionnaire Gillian commented on this, "The experience was actually quite enjoyable. The interviews were relaxed and informal".

Wendy

Wendy was aged 33 years at the time of the first interview (at 32 weeks pregnant). A twin pregnancy had been confirmed following a course of IVF treatment. Wendy had left school aged 16 years with 6 'O' levels and at the time of the pregnancy was working in an office job and described herself as a 'civil servant'. Wendy was married and her husband was employed as an export driver. Following maternity leave Wendy returned to her office job working 4 days a week. In the end of study questionnaire Wendy described herself as 'middle class'.

¹ Length of interview denotes the time for which the tape recorder was running. Conversations of course took place around the tape recorder being switched on and off, and although these will have informed my impression of the participant, I have not counted my time *with* each participant as being 'interview time'.

Interviews with Wendy

The interviews with Wendy all took place in her sisters house. Although I offered to go to her house some miles away, she suggested her sister's house would be more convenient as it was in the same village as my house. The first antenatal interview lasted just over one hour (1 hour and 3 minutes) and was relaxed. Wendy had conceived through IVF treatment and openly discussed the process. Her unhappy relationship with her husband and his family was a theme running throughout all three interviews and some months after the final interview she let me know that she had left him. The early postnatal interview² lasted approximately 1 hour 25 minutes and the final interview just under an hour (55minutes).

Linda

Linda was aged 29 years at the time of the first interview (at 32 weeks pregnant). Linda described her pregnancy as 'planned', but was unhappy that she had been made redundant just at the time she found out she was pregnant. She had left school with some 'O' levels. Linda had been employed as an office manager ("I was actually in control of other people"). Linda was married and her husband was employed as a computer manager. In the end of study questionnaire Linda described herself as 'middle class' and informed me that she was about to start a new job.

Interviews with Linda

I was only able to carry out two interviews with Linda as she had difficulties ('postnatal depression' - see chapter 7), during the early weeks/ months and chose not to be interviewed. The first interview was carried out in the home of her sister-in-law (the gatekeeper), but the final interview was carried out in her own home. The first interview lasted for just over one hour (1 hour and 4 minutes) and was relaxed and friendly. An overarching theme was that she hated her changed body shape through being pregnant and that her husband did not find 'fat' people attractive. However she was also convinced (I thought trying to convince herself) that once the baby arrived they would cope and all be happy together. The final interview also lasted just over an hour (1 hour and 3 minutes) although I stayed at her house for more than an hour after the tape recorder had been switched off. I stayed because she had been so 'down' in her interview I felt unable to leave her, so we drank coffee and talked.

Rebecca

Rebecca was aged 32 years at the time of the first interview (at 37 weeks pregnant). Rebecca described her pregnancy as 'planned in a way'. Rebecca had graduated with a BA (Hons) from Sheffield University and was employed as a 'Head of Department and Teacher' at the time of her pregnancy. Rebecca was married and her husband was employed as a 'Head of Department and Lecturer'. Following 6 months maternity leave, Rebecca returned to her old teaching job on a part-time basis. In the end of study questionnaire Rebecca described herself as 'professional'.

Interviews with Rebecca

The interviews with Rebecca took place in her home. I knew Rebecca's husband from my workplace and I felt that this made Rebecca more guarded, particularly in the first interview. She comments on the end-of-study questionnaire that she had kept "a few personal things back". The first interview lasted one hour. The early postnatal interview lasted a little longer, 1 hour and 10 minutes and the final interview only 50 minutes. The interviews were informal and a theme of personal reflection runs through the accounts. In the end-of-study questionnaire Rebecca comments that she "felt very out of control in the first couple of interviews but felt much more like myself in the last one".

Clare

²In all cases, the early postnatal interviews were the longest, followed by the antenatal interview. The shortest interviews were the late postnatal interviews.

Clare was aged 26 years at the time of the first interview (at 36 weeks pregnant). Clare's pregnancy was not planned and she had decided to continue with the pregnancy following the failure of the 'morning after pill'. Clare graduated from Birmingham University with a BA (Hons) and was employed as a teacher at the time of her pregnancy. Clare was not married but the pregnancy had led her partner to begin living with her. Her partner was also a school teacher. Clare returned to her teaching job, full-time, when her baby son was five and a half months old. In her end of study questionnaire she described herself as 'middle class'.

Interviews with Clare

The interviews with Clare were mostly relaxed and informal. In the final interview her partner sat in the room working at a desk and I certainly felt inhibited by this! This final interview only lasted 40 minutes. The antenatal interview lasted just under one hour and a theme running throughout was continued shock at being pregnant after the failure of a 'morning after pill'. The early postnatal interview lasted one hour and shock remained a theme, the shock of birth, the shock of coming home with a baby. By the third and final interview confidence and being "more my old self" were dominant themes.

Lillian

Lillian was aged 29 years at the time of the first interview (at 33 weeks pregnant). Lillian described her pregnancy as planned following an earlier miscarriage. Lillian was married and her husband ran his own small office cleaning company, whilst she was employed as a technician on a training scheme at the time of her pregnancy. Lillian hadn't returned to work by the time of the last interview, but was contemplating taking a course in accountancy "so at least I feel I'm achieving something still". Lillian moved house shortly after the final interview so an end of study questionnaire was never completed.

Interviews with Lillian

The interviews with Lillian were relaxed and informal. Lillian seemed amused by this sort of largely unstructured research. Her husband flitted in and out of the living room of their tiny, chaotic flat during the first and last interview and her friend was present during part of the second interview. Lillian was very laid back but felt that my questions would prompt her to reflect, as she said at the end of the first interview, "I'll think about all these questions and I'll think, god! I haven't asked myself that". A predominant theme in the first interview was that they would have to get themselves organised once they had a baby. The interviews all lasted approximately one hour. The last interview had to be rescheduled, when I turned up only to find they had gone to Wales for a few days to have the baby christened and had forgotten about the interview arrangement.

Philippa

Philippa was aged 29 years at the time of the first interview (at 37 weeks pregnant). Philippa described her pregnancy as 'planned'. Philippa graduated from York University with a BA (Hons) and at the time of the pregnancy was employed as a sales manager in an international publishing company. Philippa was married and her husband was a managing director of a company. She returned to her job, full - time, when her baby was 6 months old. In the end of study questionnaire she described herself as 'middle class/ professional'.

Interviews with Philippa

I really enjoyed the interviews with Philippa. At first she was concerned about whether she was 'giving me what I wanted', but when assured I was interested in whatever she wanted to say, she relaxed and spoke freely and at length. The first interview lasted for 1 hour and 10 minutes, the second was longer at 1 hour and 20 minutes and the final interview was shorter at 1 hour. This final interview was carried out in my office during Philippa's lunch break. In her end-of-study questionnaire Philippa commented on the interviews in the following way, "It is quite strange to say all these things without there being a real two-way dialogue with the researcher -it's like a counselling session without much input from the counsellor!"

Kathryn

Kathryn was aged 32 years at the time of the first interview (at 37 weeks pregnant). Kathryn described her pregnancy as 'planned' and had earlier had a miscarriage. She had graduated with a Bed (Hons) and at the time of the interview was employed as an estate secretary. Kathryn was married and her husband was a property investor. She returned to her job full-time when her baby was 6 months old. In the end of study questionnaire Kathryn described herself as 'upper middle class'.

Interviews with Kathryn

The interviews with Kathryn were mostly enjoyable and relaxed. However, in the last interview I was left feeling uncomfortable by the revelations Kathryn had made and my attempts to reassure her. I felt my research had been responsible for making her reflect and feel unhappy with aspects of her life. But I really liked Kathryn and looked forward to the interviews. In the first two interviews Kathryn presented herself as someone who was coping and had a life plan which included a beautiful house, successful husband and baby. In the final interview she started by saying that she had previously been pretending to cope and went on to 'reveal' how she had actually been experiencing early motherhood. In an extract from the end-of-study questionnaire Kathryn wrote "I looked forward to relating to experiences to Tina and felt the sessions were a catharsis".

Sarah

Sarah was by far the youngest participant in the study, she was 19 years old at the time of the first interview (at 35 weeks pregnant). Sarah described her pregnancy as 'unplanned' and her boyfriend as being 'horrified', but supported by her Buddhist parents, she said she never considered not going ahead with the pregnancy. Sarah described her occupation as 'home maker and sandwich maker' and had been employed in a sandwich making business until early in her pregnancy. Her non-resident boyfriend was at college. Whilst she didn't give any details about her education, Sarah described herself as 'in between working and middle class' in the end of study questionnaire. She did not return to work during the course of the study.

Interviews with Sarah

The first two interviews with Sarah took place at her parents home where she was living, by the time of the final interview she had her own home. Sarah lived what appeared to be a chaotic life and on one occasion I arrived late morning to find her still in bed. The interview was carried out over a very late breakfast! Sarah presented herself as very laid back and relaxed during the first two interviews but by the last spoke of the shock of giving birth and being a mother. I felt anxious before the interviews with Sarah because I never knew what to expect, her lifestyle was unpredictable! But this also made the interviews all the more interesting.

Abigail

Abigail was aged 28 years at the time of the first interview (at 35 weeks pregnant). Abigail described her pregnancy as 'planned'. She was employed as a computer programmer at the time of her pregnancy. Abigail was married and her husband was employed as a product manager. She returned to her job on a full-time basis once her baby was five months old. In the end of study questionnaire Abigail described herself as 'middle' class.

Interviews with Abigail

The interviews with Abigail were great fun to do, largely because she was very straight talking. She did not enjoy being pregnant and likened her condition to being in the film, 'The Alien'. In the next interview she spoke of her surprise at how 'undignified' the birth had been and the 'smells' associated with childbirth and the period after. The interviews always felt very relaxed and Abigail was someone I looked forward to returning to. In fact because the tape machine failed on one occasion, I did return to repeat one interview.

Sheila

Sheila was 32 years old at the time of the first interview (at 33 weeks pregnant). She described the pregnancy as 'partly planned'. Sheila had left school aged 18 years with 1 'A/S' level and went on to take a secretarial course and was employed as a secretary at the time she found out she was pregnant. Sheila was married and her husband was employed as a fire-fighter. Sheila did not anticipate returning to her secretarial job following the birth of her twins, but thought she might take on occasional agency work. In the end of study questionnaire Sheila described herself as 'middle/working' class.

Interviews with Sheila

I remember feeling that Sheila was bemused and confused by the first interview, I think she had anticipated something more formal. In the second interview Sheila's mother was present throughout. This was not as inhibiting for me as it might have been but I was aware that it may have inhibited Sheila. The final interview was conducted around a dining room table, the twin babies sitting in high chairs being fed in turn. Sheila was much more self-assured in this final interview and was clearly demonstrating to me both verbally and practically that she was coping as a mother of twins. A theme running through this final interview was that she was the expert on her babies, experiences and getting through had led her to this position.

Felicity

Felicity was 32 years at the time of the first interview (at 38 weeks pregnant). She acknowledges that 'it wasn't a planned pregnancy'. Felicity was employed on a temporary basis as a university lecturer at the time of her pregnancy. She was married and her husband was employed as a stock broker. Felicity's contract had come to an end before the birth and her husband's job was to lead to a relocation. Despite attempts to contact Felicity at the time of the final interview, contact was never re-established and a final interview was not carried out. An end of study questionnaire was not completed.

Interviews with Felicity

Felicity worked as an academic and being interviewed was something she appeared to enjoy. Although confident about the process of what this type of interviewing involved, Felicity was absolutely bewildered by her pregnant state. The first interview took place at my home as this was more convenient to Felicity. My professional tape recorder had broken and I had to make do with a very brightly coloured 'Fisher Price' child's tape recorder to record our interview. However Felicity found this amusing and the interview proceeded easily. The first postnatal interview took place in Felicity's home in the midst of removal men, her husband and her mother. They were moving that day. Finding a quiet corner, the tone of this interview was completely different to the earlier antenatal interview. Felicity had a long, difficult and bewildering birth with subsequent problems. She seemed relieved to have someone to share this with, but at the same time felt that even I had not told her about the pain of childbirth. Felicity was moving house and County on the day of this interview and contact was lost.

Diana

Diana was 34 years at the time of the first interview (at 36 weeks pregnant). She described the pregnancy as 'planned' and felt 'delight and amazement' having tried to conceive for 18 months. Diana was employed as a company lawyer at the time of her pregnancy and returned to her job on a part-time basis when her baby was seven and a half months old. Diana was married and her husband was employed as an accountant. In the end of study questionnaire Diana described herself as 'working' class.

Interviews with Diana

I really enjoyed the interviews with Diana. She was clearly concerned at the beginning of the first interview and had wondered what sort of questions I might want to ask, but she relaxed once she realised how the interviews worked i.e. 'conducted in the form of an informal chat' (end of study questionnaire). The subsequent interviews were always relaxed and for me, enjoyable. Diana was one of the participants I looked forward to returning to see. I am still in contact by letter with Diana. This came about because she wrote to let me

know that her sister had tragically committed suicide following a period of postnatal depression that she had felt unable to tell anyone about.

Helen

Helen was 30 years old at the time of the first interview (at 35 weeks pregnant). She described the pregnancy as 'planned'. Helen was employed as a recruitment manager at the time she found out she was pregnant. She was married and her husband was a hairdresser and salon owner. Helen did not anticipate returning to work once her baby was born. In her end of study questionnaire Helen describes herself as 'working/middle' class.

Interviews with Helen

Helen was a friend of Diana and she told me at our first interview that Diana had telephoned her to reassure her that I was okay and that the interviews were enjoyable. Helen was absolutely thrilled to be pregnant and I could have predicted, following our first meeting, that if anyone was going to have problems it would be Helen. This was because she was so exceptionally involved with every aspect of pregnancy and becoming a mother. Helen knew exactly what she wanted and how things would be. During the second interview, following a long and difficult birth and delivery by caesarian, Helen continued to present a happy, upbeat account of her experiences. But in the final interview and in her end of study questionnaire, Helen revealed how she had really been feeling, the difficulties of early mothering and her disappointment at feeling unable to cope at times.

Faye

Faye was 31 years at the time of the first interview (at 37 weeks pregnant). She described the pregnancy as 'planned'. Faye had left school aged 17 years with 5 'O' levels and a BEC Business studies qualification and had worked as a local government officer until she was made redundant in early pregnancy. Faye was married and her husband was employed as a project manager and engineer. Because Faye had been made redundant she had no plans to return to an existing job, but rather had secured a place on a part-time photography course to commence once the baby was born. In the event, she did not take up this place and remained at home. In her end of study questionnaire Faye described herself as 'working/professional' class.

Interviews with Faye

I found the interviews with Faye quite difficult. This was because Faye did not seem to relax or enjoy the interviews. She appeared to think that I wanted 'right' answers, as though she were being tested and assessed in some way. I did not look forward to returning to do the early postnatal interview, but this time Faye seemed more relaxed and clearly she now knew what to expect. In one of the postnatal interviews Faye commented that she wasn't very good with words and this seemed to provide a key to her apparent reluctance in earlier interviews to voice her experiences.

Peggy

Peggy was aged 29 years at the time of the first interview (at 35 weeks pregnant). Peggy described the pregnancy as 'sort of planned'. Peggy had been employed as a teacher at the time of her pregnancy and was undecided whether she would return to teaching once her baby was born. She was married and her husband was employed as a computer programmer. In her end of study questionnaire Peggy described herself as 'professional'.

Interviews with Peggy

The interviews with Peggy were relaxed and Peggy seemed bemused by the research approach. I met Peggy at her house for the interviews, she had been introduced to me by a colleague of hers who was also in the study. When we met she had begun her maternity leave from her job as a teacher and was delighted to now have time to indulge her passion of horse riding. Animals were a recurrent theme in the interviews and she compared her later experiences of being a mother with having animals to look after. Peggy lived close to her parents and in the months following the birth of her baby she had daily practical support from them as they helped with childcare. This situation clearly eased Peggy's

experiences of becoming a mother and she noted their contribution in the end of study questionnaire. Although Peggy seemed to almost wonder why anyone should be interested in experiences of first-time motherhood, she commented in the end of study questionnaire that through the interviews 'it was quite good to have the chance to reflect on what had happened to my life'.

APPENDIX 8.

Women's Experiences of Becoming Mothers: End of Study Questionnaire.

This questionnaire is designed to gather some general details about you and more particularly about your experience of being a participant in this research project. Please complete Section 1 and add extra pages to Section 2 if you wish.

Section 1: General Details

1. Your date of birth

| | | | | | |
|---|---|---|---|---|---|
| 2 | 6 | 0 | 7 | 6 | 3 |
|---|---|---|---|---|---|
2. Age at which you left school 18
3. Educational achievement(s) BEd Hons, 2 A levels, 9 O levels
4. Your occupation (if applicable) estate secretary
5. Partners occupation (if applicable) property investor
6. How many weeks pregnant were you when you started maternity leave? (if applicable) 38
7. Have you now returned to work? yes
8. How many weeks/months after the birth did you return to work? 29 weeks
9. If asked to describe which social class or group you would place yourself in, which would it be? upper middle class

Section 2: The Research Process

The following section is about your own experiences of being a participant in this study.

10. How would you describe being a participant in this research project? (for example you might like to include your thoughts on the interviews, their regularity, the researcher etc..) *Please continue on a separate sheet if you wish.*

I enjoyed taking part in the research and look forward to reading the outcome.

I was very impressed by the interviewer and I felt able to relate easily with her. The subject of pregnancy and motherhood is so intensely personal that one is often reluctant to discuss it openly, but I felt very relaxed with Tina and felt I could trust her.

The interviews were at well-spaced intervals and came at, what were for me, very significant stages: at 8 months, having had a wonderful pregnancy, I was longing for it all to be over! With my baby at 8 weeks old, so much had happened and so many changes were taking place almost daily that it was hard to assimilate everything and the interview helped to consolidate my feelings. Nine months later,

11. If you would like to add anything further, please do so in the space below

butd...

I had come to terms with the enormity of the changes and it was helpful to analyse, through the research project, why I had reacted in certain ways to different things. I looked forward to relating my experiences to Tina and felt the sessions were a catharsis!

Finally, **thankyou** for **your** involvement in the study as without you it would not have been possible. If you would be interested in receiving news of the findings from the study - which won't be until summer 1998 - please tick this box

☒

and add your contact address below.

Women's Experiences of Becoming Mothers: End of Study Questionnaire.

This questionnaire is designed to gather some general details about you and more particularly about your experience of being a participant in this research project. Please complete Section 1 and add extra pages to Section 2 if you wish.

Section 1: General Details

1. Your date of birth

| | | | | | |
|---|---|---|---|---|---|
| 2 | 8 | 0 | 2 | 6 | 6 |
|---|---|---|---|---|---|

2. Age at which you left school 29

3. Educational achievement(s) GCE'S 10' level.

4. Your occupation (if applicable) REDUNDANT.

5. Partners occupation (if applicable) COMPUTER MANAGER.

6. How many weeks pregnant were you when you started maternity leave? (if applicable) N/A.

7. Have you now returned to work? NEW JOB 4th NOV.

8. How many weeks/months after the birth did you return to work? N/A.

9. If asked to describe which social class or group you would place yourself in, which would it be? MIDDLE

Section 2: The Research Process

The following section is about your own experiences of being a participant in this study.

10. How would you describe being a participant in this research project? (for example you might like to include your thoughts on the interviews, their regularity, the researcher etc..) *Please continue on a separate sheet if you wish.*

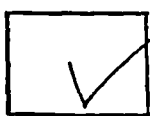
I would have being a participant in the research would help other woman, as I felt it very interesting to listen to the tales of myself while being pregnant.

Tina is making a great achievement for woman. I hope in enlightening us all, that we are allowed to feel the way we do.

Well done Tina and thank-you.

11. If you would like to add anything further, please do so in the space below

Finally, **thankyou** for **your** involvement in the study as without you it would not have been possible. If you would be interested in receiving news of the findings from the study which won't be until summer 1998 - please tick this box ☒ and add your contact address below.



Women's Experiences of Becoming Mothers: End of Study Questionnaire.

Section 1: General Details

1. Age 31
2. Your Occupation (if applicable) Recruitment Manager
3. Partners Occupation (if applicable) Hairdresser / Salon Owner
4. How many weeks pregnant were you when you started maternity leave? (if applicable) 32 weeks.
5. Have you now returned to work? No
6. If asked to describe which social class or group you would place yourself in, which would it be? Working / Middle class.

Section 2: The Research Process

The following section is about your own experiences of being a participant in this study.

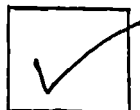
7. How would you describe being a participant in this research project? (for example you might like to include your thoughts on the interviews, their regularity, the researcher etc..) *Please continue overleaf if you wish to.*

Although initially feeling rather apprehensive and not knowing what to expect from the interviews, Tina made me feel completely at ease. But I do think, had I had prior knowledge of the type of questions and structure of interview I may have been able to contribute more detailed answers. e.g at the end of the first interview I felt I had just 'waffled' for an hour. 267

IN the second interview, it was one of the first times anyone had taken so much time in concentrating on my emotional state (even more than the health visitor) - but I now realise that I was not being 100% honest with my answers and was too eager to attempt to create a feeling of control, relaxation and total happiness and contentment (In fact I was feeling quite disorientated and out of control).

8. If you would like to add anything further, please do so in the space below (*continue overleaf if you wish*)

Finally, **thankyou** for **your** involvement in the study as without you it would not have been possible. If you would be interested in receiving news of the findings from the study - which won't be until summer 1998 - please tick this box



Women's Experiences of Becoming Mothers: End of Study Questionnaire.

This questionnaire is designed to gather some general details about you and more particularly about your experience of being a participant in this research project. Please complete Section 1 and add extra pages to Section 2 if you wish.

Section 1: General Details

1. Your date of birth

| | | | | | |
|---|---|---|---|---|---|
| 2 | 1 | 1 | 2 | 6 | 3 |
|---|---|---|---|---|---|
2. Age at which you left school 18
3. Educational achievement(s) 6 'O' LEVELS, 3 CSE'S, 1 'AS' LEVEL, SECRETARIAL COURSE
4. Your occupation (if applicable) HOUSEWIFE
5. Partners occupation (if applicable) FIREFIGHTER
6. How many weeks pregnant were you when you started maternity leave? (if applicable) 34 WEEKS
7. Have you now returned to work? NO
8. How many weeks/months after the birth did you return to work? N/A
9. If asked to describe which social class or group you would place yourself in, which would it be? MIDDLE / WORKING

Section 2: The Research Process

The following section is about your own experiences of being a participant in this study.

10. How would you describe being a participant in this research project? (for example you might like to include your thoughts on the interviews, their regularity, the researcher etc..) *Please continue on a separate sheet if you wish.*

I thoroughly enjoyed being a participant ~~the~~ in this research project. I found the interviews very thought provoking and good for myself because it gave me time to sit and reflect on my life and also to see how my views changed once babies arrived.

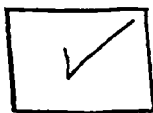
The regularity of the interviews at first I thought was very strange but now the research project is completed I can see why these times were chosen and think they worked very well. I found the researcher very easy to talk to and very understanding.

11. If you would like to add anything further, please do so in the space below

The only thing that I feel I didn't convey very well at the last interview was the fact that my husband and my social life is now based on doing all the household chores in the evening as well as preparing babies food for the next few days/weeks!

I don't know whether this is because we have twins because obviously it is really best if two people babysit rather than one and that can be quite difficult to arrange especially as all our brothers + sisters have children of their own as well as our friends. Neither of us mind this though as ^{we are very happy parents!!}

Finally, **thankyou** for ~~your~~ involvement in the study as without you it would not have been possible. If you would be interested in receiving news of the findings from the study - which won't be until summer 1998 - please tick this box



and add your contact address below.

Women's Experiences of Becoming Mothers: End of Study Questionnaire.

This questionnaire is designed to gather some general details about you and more particularly about your experience of being a participant in this research project. Please complete Section 1 and add extra pages to Section 2 if you wish.

Section 1: General Details

1. Your date of birth

| | | | | | |
|---|---|---|---|---|---|
| 0 | 9 | 0 | 8 | 6 | 4 |
|---|---|---|---|---|---|
2. Age at which you left school 17
3. Educational achievement(s) 3 O'LEVELS, 5 C.S.E'S,
PASS-SECRETARIAL COURSE, PASS-(A.A.T) ASSOCIATION OF ACCOUNTING TECHNIC
4. Your occupation (if applicable) SECRETARY (P/T)
5. Partners occupation (if applicable) PRODUCTION WORKER
6. How many weeks pregnant were you when you started maternity leave? (if applicable) APPROX 37 WEEKS
7. Have you now returned to work? YES
8. How many weeks/months after the birth did you return to work? APPROX 15 WKS
9. If asked to describe which social class or group you would place yourself in, which would it be? MIDDLE CLASS

Section 2: The Research Process

The following section is about your own experiences of being a participant in this study.

10. How would you describe being a participant in this research project? (for example you might like to include your thoughts on the interviews, their regularity, the researcher etc..) *Please continue on a separate sheet if you wish.*

ABIT NERVE-WACKING TO START WITH, AS UNSURE WHAT'S 'EING TO HAPPEN. THE RESEARCHER WAS VERY FRIENDLY, SO THAT HELPED TO PUT ONESELF AT EASE. THEY ALSO HAD A LIST OF QUESTIONS WHICH ASSISTED WITH THE FLOW OF INTERVIEW.

MAYBE AS WELL AS A TALK, A MULTIPLE CHOICE SECTION, (E.G. SECTION 2, Q. 10 OF THIS QUESTIONNAIRE COULD BE A MULTIPLE CHOICE). IT'S VERY OFF-PUTTING SEEING A BIG BLANK PAGE WHICH YOU ARE EXPECTED TO FILL IN.

I WOULD BE INTERESTED IN HEARING WHAT OTHER NEW MOTHERS HAVE TO SAY TO SEE IF THEY HAD THE SAME EXPERIENCES

OVERALL, I FOUND THE STUDY TO BE WELL PRESENTED, IN A RELAXED AND INFORMAL WAY. I LOOK FORWARD TO READING THE RESULTS

11. If you would like to add anything further, please do so in the space below

Finally, **thankyou** for **your** involvement in the study as without you it would not have been possible. If you would be interested in receiving news of the findings from the study - which won't be until summer 1998 - please tick this box ☐ and add your contact address below.

Women's Experiences of Becoming Mothers: End of Study Questionnaire.

This questionnaire is designed to gather some general details about you and more particularly about your experience of being a participant in this research project. Please complete Section 1 and add extra pages to Section 2 if you wish.

Section 1: General Details

1. Your date of birth

| | | | | | |
|---|---|---|---|---|---|
| 0 | 9 | 0 | 7 | 6 | 2 |
|---|---|---|---|---|---|
2. Age at which you left school 16 yrs ('A' Levels)
3. Educational achievement(s) 8 'O' Grades, 4 'Highers',[✓]
UB.
4. Your occupation (if applicable) Lawyer
5. Partners occupation (if applicable) Accountant
6. How many weeks pregnant were you when you started maternity leave? (if applicable) 33
7. Have you now returned to work? Yes (part-time)
8. How many weeks/months after the birth did you return to work? 7 1/2 mths
9. If asked to describe which social class or group you would place yourself in, which would it be? working

Section 2: The Research Process

The following section is about your own experiences of being a participant in this study.

10. How would you describe being a participant in this research project? (for example you might like to include your thoughts on the interviews, their regularity, the researcher etc..) *Please continue on a separate sheet if you wish.*

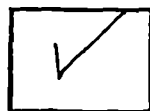
I was extremely keen to participate in the study from the outset. I had always wondered how data for such research projects was obtained (and from whom) and now I was about to find out! I felt a bit apprehensive prior to the initial interview and worried that I wouldn't be able to provide the 'right' answers. However, my fears were soon dispelled when I met the researcher and realised that the interviews were to be conducted in the form of an informal chat and, more importantly, she did not expect model answers, only *my* answers.

[The interviews themselves were extremely adept at making me consider certain issues and feelings which I might otherwise have dismissed. It was also fascinating to look back at the way in which I had responded in previous interviews and then to consider my changing views and feelings. It also helped me to rationalise my otherwise irrational thought process!!] I think the interviews were timed to perfection, possibly because the researcher was herself a mother and therefore understood the amazing swing of emotions during that very short period and of course the complete memory lapse that occurs in relation to LBB (life before baby) once you have accepted that the life you are now living is yours (not someone else's), and that the baby is here to stay!!

In conclusion, I found the experience positive and rewarding and I look forward to reading the results in due course.

11. If you would like to add anything further, please do so in the space below

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Section 1: General Details

1. Your date of birth

| | | | | | |
|---|---|---|---|---|---|
| 1 | 4 | 1 | 1 | 6 | 2 |
|---|---|---|---|---|---|
2. Age at which you left school 17
3. Educational achievement(s) Nine GCE 'O' levels, grades A & B.
Registered General Nurse.
4. Your occupation (if applicable) Nursing Sister
5. Partners occupation (if applicable) Builder
6. How many weeks pregnant were you when you started maternity leave? (if applicable) 32 (ish)
7. Have you now returned to work? very occasionally - 10 to 20 hours/week
8. How many weeks/months after the birth did you return to work? 9 months
9. If asked to describe which social class or group you would place yourself in, which would it be? "Middle class" or Group B.

Section 2: The Research Process

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The experience was actually quite enjoyable!
The interviews were relaxed and informal and
were made at a time convenient to me.
The opportunity to talk about oneself for
a few sessions is not one to miss.

I am looking forward to results on the study
and I will also be interested to see my own
perceptions of birth before and after the event
which I have already forgotten.

The researcher was relaxed, friendly and
professional.

11. If you would like to add anything further, please do so in the space below

Finally, **thankyou** for **your** involvement in the study as without you it would not have been possible. If you would be interested in receiving news of the findings from the study - which won't be until summer 1998 - please tick this box

☒

and add your contact address below.

we have just sold our house & have no new address yet.

1m, Sorry its so late! H was buried under a pile of school books!!

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Section 1: General Details

1. Your date of birth

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|---|---|---|---|---|---|
| 0 | 4 | 0 | 3 | 6 | 9 |
|---|---|---|---|---|---|

2. Age at which you left school 18

3. Educational achievement(s) 9 'O' levels 3 'A' levels
Geog. (B.A Hons) from Birmingham Uni. P.G.C.E.

4. Your occupation (if applicable) TEACHER

5. Partners occupation (if applicable) TEACHER

6. How many weeks pregnant were you when you started maternity leave? (if applicable) 28

7. Have you now returned to work? YES

8. How many weeks/months after the birth did you return to work? 5 1/2 months

9. If asked to describe which social class or group you would place yourself in, which would it be? Middle class

Section 2: The Research Process

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I enjoyed the interview. Tina was easy to talk to and I didn't feel as if I was being 'grilled' / 'judged' etc. It helped that she was able to offer some of her own experiences.

A couple of the questions I found hard to answer eg. 'how do you think you've changed?' - probably because I'd never really thought about it before. In that respect I found my own reflections interesting.

I'd be interested to see the 'final product' to see how other mothers felt / coped etc.

11. If you would like to add anything further, please do so in the space below

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Women's Experiences of Becoming Mothers: End of Study Questionnaire.

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Section 1: General Details

1. Your date of birth

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|---|---|---|---|---|---|
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|---|---|---|---|---|---|

2. Age at which you left school 18

3. Educational achievement(s) Barnsley history (York)

4. Your occupation (if applicable) Journal Sales Manager

5. Partners occupation (if applicable) Managing Director

6. How many weeks pregnant were you when you started maternity leave? (if applicable) 37

7. Have you now returned to work? Yes

8. How many weeks/months after the birth did you return to work? 6 months

9. If asked to describe which social class or group you would place yourself in, which would it be? middle class / -

professional

Section 2: The Research Process

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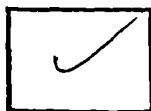
Interesting It made me formulate + articulate thoughts on my experience of pregnancy, childbirth + becoming a mother, and gave me a forum for discussing them.

It is quite strange to say all these things without there being a real 2-way dialogue with the researcher. It is like a counselling session without much input from the counsellor!

The regularity of the interviews seemed sensible to me, and broadly reflected my changing feelings.

11. If you would like to add anything further, please do so in the space below

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Women's Experiences of Becoming Mothers: End of Study Questionnaire.

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Section 1: General Details

1. Your date of birth

| | | | | | |
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|---|---|---|---|---|---|

2. Age at which you left school 16

3. Educational achievement(s) 6 GCSE's

4. Your occupation (if applicable) Civil Servant

5. Partners occupation (if applicable) Export Driver

6. How many weeks pregnant were you when you started maternity leave? (if applicable) 36

7. Have you now returned to work? Yes

8. How many weeks/months after the birth did you return to work? 9

9. If asked to describe which social class or group you would place yourself in, which would it be? Middle

Section 2: The Research Process

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I can't remember very much about it now - the questions were set out ~~good~~ very well. & Tina was excellent

I did write more on the other form but can't remember what I done with it - Sorry.

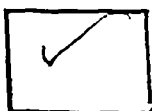
11. If you would like to add anything further, please do so in the space below

Tina

The boys are doing fine
is waiting & has been for about
a month. Started taking a few
Steps today - won't be long - then
I'll have to have eyes in the back of
my head... I still couldn't be without
(sister) - She's brilliant
don't forget you ever get to publish
a book on this study I want one!
& I want her tape!!

Might see you soon

Finally, **thankyou** for **your** involvement in the study as without you it would not have been possible. If you would be interested in receiving news of the findings from the study - which won't be until summer 1998 - please tick this box



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Women's Experiences of Becoming Mothers: End of Study Questionnaire.

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Section 1: General Details

1. Your date of birth

| | | | | | |
|--|---|---|---|---|---|
| | 5 | 1 | 0 | 6 | 2 |
|--|---|---|---|---|---|

2. Age at which you left school

18

3. Educational achievement(s)

BA Hons (Sheffield)
P.G.C.E. (Westminster College, Oxford)

4. Your occupation (if applicable)

Head of Dept. & Teacher

5. Partners occupation (if applicable)

Lecturer & Head of Dept

6. How many weeks pregnant were you when you started maternity leave? (if applicable)

35

7. Have you now returned to work?

Yes

8. How many weeks/months after the birth did you return to work?

6 months
with

9. If asked to describe which social class or group you would place yourself in, which would it be?

Professional

Section 2: The Research Process

The following section is about your own experiences of being a participant in this study.

10. How would you describe being a participant in this research project? (for example you might like to include your thoughts on the interviews, their regularity, the researcher etc..) *Please continue on a separate sheet if you wish.*

Interviews very interesting & well led -
informal but professional !!
Researcher very professional yet approach-
- felt I could discuss almost everything
(did keep a few personal things back!)
Regularity good from my point of view
felt I'd changed since last interview.
I'd be very interested to hear the
tapes - I felt very 'out of control'
(see over) in the first couple of interviews
but felt much more like myself in the
last one. How interesting to follow up
for about a year but especially before
after childbirth! Becoming a mother makes
feel ^{like} an active participant in a much larger
scene of things.

11. If you would like to add anything further, please do so in the space below

Tina & I discussed the idea of "Control" which was interesting (after the form taped interview.) I felt I'd usually been in control before becoming pregnant & I am mostly in control now but during pregnancy & just few months of having Holly felt less in control (of my own emotions, mainly, but felt this was due to hormones etc, ^{and my father's} rather an invasion ^{of} into my life by medical staff/other mother's recommendations etc.

P.T.O.

Finally, **thankyou** for **your** involvement in the study as without you it would not have been possible. If you would be interested in receiving news of the findings from the study - which won't be until summer 1998 - please tick this box ☒ and add your contact address below.

people sometimes make out that pregnancy
child saving has its "own knowledge"
but I feel you approach it like everything
else - your own way therefore when medi-
cists don't seem to give any answers be-
cause they probably respect your responsibility
to the parent to do what you think
is best, given the circumstances.

I felt as though my life changed
forever when I was pregnant rather than
being a mother. Being pregnant was
awesome, being a mother is just, rewarding
is a natural development for me -
~~filling~~ filling a gap I didn't realize I
had. I feel my life is good & right.
(however my daughter's only 9 months - I
wonder if I'd feel the same ~~if~~ if she
becomes a wayward teenager !!)

Thanks for involving me!!

Women's Experiences of Becoming Mothers: End of Study Questionnaire

Section 1: General Details

1. Age 29
2. Your Occupation (if applicable) Computer Programmer
3. Partners Occupation (if applicable) Product Manager
4. How many weeks pregnant were you when you started maternity leave? (if applicable) 36
5. Have you now returned to work? Yes
6. If asked to describe which social class or group you would place yourself in, which would it be? Middle

Section 2: The Research Process

The following section is about your own experiences of being a participant in this study.

7. How would you describe being a participant in this research project? (for example you might like to include your thoughts on the interviews, their regularity, the researcher etc..) *Please continue overleaf if you wish to.*

I enjoyed the interviews. They were very relaxed and it was beneficial to actually think of my feelings and so to understand them more fully. I am interested in the end result from the study to see how others felt during pregnancy.

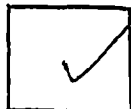
The time between interviews seemed to fly by. But then so has the whole year.

8. If you would like to add anything further, please do so in the space below (*continue overleaf if you wish*)

Sorry for the delay - Managed to forget all about it!
We haven't moved & have no plans to in the near future.

Thanks for including me!

Finally, **thankyou** for your involvement in the study as without you it would not have been possible. If you would be interested in receiving news of the findings from the study - which won't be until summer 1998 - please tick this box



Women's Experiences of Becoming Mothers: End of Study Questionnaire.

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Section 1: General Details

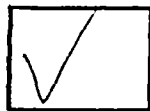
1. Your date of birth

| | | | | | |
|---|---|---|---|---|---|
| 2 | 1 | 0 | 8 | 9 | 6 |
|---|---|---|---|---|---|
2. Age at which you left school 17
3. Educational achievement(s) 5 O' levels & qualifica
connected to work BEC National Business.
4. Your occupation (if applicable) Mother
5. Partners occupation (if applicable) Project manager/Engineer
6. How many weeks pregnant were you when you started maternity leave? (if applicable) 20 to 25 weeks
7. Have you now returned to work? No
8. How many weeks/months after the birth did you return to work? /
9. If asked to describe which social class or group you would place yourself in, which would it be? Working / professional

11. If you would like to add anything further, please do so in the space below

I don't think anything can prepare you for motherhood we planned the time we had our daughter & have been together for 10 years so this was rushed into. I ~~wasn't~~ didn't realise how emotional I would become about child generally. I am now at home full time after taking redundancy when I became pregnant which is a completely different lifestyle & I miss the social side of working. I don't know I would have liked being my daughter at a young age of 3 months which is standard in this country. I think mothers should be allowed a lot longer at home.

Finally, **thankyou** for your involvement in the study as without you it would not have been possible. If you would be interested in receiving news of the findings from the study - which won't be until summer 1998 - please tick this box



and add your contact address below.

Women's Experiences of Becoming Mothers: End of Study Questionnaire

Section 1: General Details

1. Age 30 (29 at Birth)
2. Your Occupation (if applicable) full time mother (ex-teacher)
3. Partners Occupation (if applicable) Computer Programmer
4. How many weeks pregnant were you when you started maternity leave? (if applicable) 26 weeks (end of summer term)
5. Have you now returned to work? No
6. If asked to describe which social class or group you would place yourself in, which would it be? Professional (?)

Section 2: The Research Process

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7. How would you describe being a participant in this research project? (for example you might like to include your thoughts on the interviews, their regularity, the researcher etc..) *Please continue overleaf if you wish to.*

Mostly sensible, easy to answer questions; Tina was very easy to talk to. At the 3rd interview I didn't recognise any of my answers to the 2nd one so I must have been suffering from post-natal amnesia of some sort. (amnesia?) I always thought of lots of things I'd wanted to say after the interview was finished; 299 but of course had forgotten them completely by the next interview.

It was quite good to have the chance to reflect
on what had happened to my life. I think also
from talking to Tina it made me realise how lucky
I am to have parents who give me so much help,
(My parents loved the days after her visits) also it was
nice for me to be the focus rather than

8. If you would like to add anything further, please do so in the space below (*continue overleaf if you wish*)

Finally, **thankyou** for **your** involvement in the study as without you it would not have been possible. If you would be interested in receiving news of the findings from the study - which won't be until summer 1998 - please tick this box



Women's Experiences of Becoming Mothers: End of Study Questionnaire

Section 1: General Details

1. Age 21 (30.06.76)
2. Your Occupation (if applicable) Home maker (same as partner)
3. Partners Occupation (if applicable) College
4. How many weeks pregnant were you when you started maternity leave? (if applicable) 7 months
5. Have you now returned to work? No
6. If asked to describe which social class or group you would place yourself in, which would it be? In between working & middle class

Section 2: The Research Process

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7. How would you describe being a participant in this research project? (for example you might like to include your thoughts on the interviews, their regularity, the researcher etc..) Please continue overleaf if you wish to.

It has been a pleasure talking part, I only hope my input will be able to help other. Maybe there could ~~be~~ been ~~one~~ ~~other~~ interview say at 2 years old as a little bit more. More interviews say on women in the group ²⁰²¹ if they have a another child. (I don't know that would

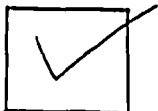
rk in practice, the woman
did have to get pregnant a
~~new~~ course.)

ina miller was really great.
hd patient during the interview
ngst the chaos of my home.

8. If you would like to add anything further, please do so in the space below (*continue overleaf if you wish*)

It will be interesting to find out if I have had shared experience with other women, and if I can ~~the~~ gain information for the future.

Finally, **thankyou** for your involvement in the study as without you it would not have been possible. If you would be interested in receiving news of the findings from the study - which won't be until summer 1998 - please tick this box



Spoke to Resp #4 again (having phoned her last week) we spoke for 15-20 minutes - apparently both the Res. husband & Health visitor don't think she should progress with the interviews - but I feel she wants to, if only to have someone to talk to. I said I did not want to put any pressure on her, especially as others thought she should not proceed. She was unhappy that the health visitor has asked her to fill out a depression scoring questionnaire - she had scored 16 points and then 17 on the next occasion and so had been 'labelled' / diagnosed as suffering from postnatal depression and prescribed anti-depressants. She was angry that she had been labelled in this way and treated with drugs (the implication was that she was not taking the drugs). She spoke of being lonely and 'stuck out here', isolated. After a long talk - with me telling her that not all women found becoming mothers easy - she arranged to meet me next Tuesday at her house for a p/n interview. I gave her my home number and said to phone me on Tuesday morning if she didn't feel up to being interviewed - although I sense that she will be relieved once she has been interviewed (fulfilled her 'obligations' to me → I am also aware of my position/role as researcher and not professional counsellor, but as a mother I empathise and realise I may find it difficult to disentangle / keep my various 'roles' separate.

20/1/96 - I have just ^{↑ ("hysterical", almost)} been telephoned by who sounded cheerful, but said she was phoning from her parents and therefore couldn't be interviewed

ready. She apologised but said she was working
lunch for her Dad. She said she would phone me
(I suggested Thursday) at the office, or at home
to arrange another time. I feel frustrated as I
had my coat on ready to leave, and had prepared
to 'do' the interview after what has already been a
frustratingly long build up. Will she contact me??
- another thought, J. said she had had to contact
J. (her husband) to get him to phone his sister (who
lives in village) to get my phone number - which
means / implies that she has informed J. (husband) she was
going to meet me - and I know that he didn't
think she should.

Also interesting the concept of 'Tune' - the stage at
which - feels able to 'present' herself to me
again.

-(Later thoughts) what does this say about
'control' in * life?

15/2/95 - hasn't phoned, I wonder if I should
send my ~~own~~ semi-structured interview sheet
in the form of a self-administered questionnaire.
- I will talk to Judith about this (Ethics?!)